



 International Federation
of Red Cross and Red Crescent Societies

Humanitarian Aid
and Civil Protection

EXTERNAL EVALUATION
KENYA RED CROSS SOCIETY
PROVISION OF EMERGENCY HEALTHCARE IN
DROUGHT AFFECTED AREAS RESPONSE
OCTOBER 2011- JUNE 12



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ACRONYMS

| | |
|---------|---|
| ASAL | Arid and Semi Arid Lands |
| CFR | Case Fatality Rate |
| CHC | Community Health Committee |
| CHEW | Community Health Extension Worker |
| CHW | Community Health Worker |
| CHU | Community Health Unit |
| CLTS | Community Led Total Sanitation |
| DHMT | District Health Management Team |
| DPHO | District Public Health Officer |
| DRR | Disaster Risk Reduction |
| GAM | Global Acute Malnutrition |
| GoK | Government of Kenya |
| HH | Household |
| HMIS | Health Management Information System |
| IEC | Information, Education and Communication |
| IFRC | International Federation of Red Cross and Red Crescent Societies |
| KEPH | Kenya Essential Package for Health |
| KRCS | Kenya Red Cross Society |
| M&E | Monitoring and Evaluation |
| MoPHS | Ministry of Public Health and Sanitation |
| ORS | Oral Rehydration Solution |
| PHASTER | Participatory Hygiene and Sanitation Training in Emergency Response |
| SAM | Severe Acute Malnutrition |
| SHEPP | School Hygiene Education and Promotion Programme |
| UNICEF | United Nations Children's Fund |
| WatSan | Water and Sanitation |

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EXECUTIVE SUMMARY

The Kenya Red Cross Society (KRCS), supported by the International Federation of Red Cross and Red Crescent Societies (IFRC), implemented an emergency health intervention in northern Kenya: ***“Provision of emergency healthcare in drought affected areas of Kenya”***. The project aimed to a) prepare for and respond to outbreaks of cholera, and b) provide emergency healthcare for Somali refugees in the transition area between the Kenya/Somalia border and the Dadaab refugee camps. The project period was initially approved for 6 months to run from October 1st 2011 to March 31st 2012 and was funded by the European Commission Directorate General for Humanitarian Aid and Civil Protection (DG-ECHO), with a grant worth 1 million Euro. Due to various delays in implementation, a no cost extension of 3 months was granted, for a final completion date of 30 June 2012.

The KRCS emergency health care response was a highly ambitious project for an initially proposed six month time period, which as a result experienced several challenges during its implementation. As a result of changing circumstances throughout the project period, including the confirmed cholera outbreak in Dadaab refugee camp, as well as variance of field realities in different targeted sites, there were revisions to the original proposal to adapt to and address the realities and needs on the ground. Significant achievements were realized as a result of this project, most notably the much needed assistance to the cholera response in Dadaab, the support to the roll out of the Government of Kenya’s (GoK) community health strategy, the capacity building of communities to take responsibility for their own health, and the distribution of much needed supplies and resources to health facilities. In particular, the support provided by KRCS for the roll out of the community health strategy was seen as a positive step to ensuring these efforts can continue to be built upon, with notable changes and improved health and hygiene practices already being recognized within the targeted communities.

Feedback from the KRCS staff, volunteers, district authorities and communities support the conclusion that the KRCS emergency health care project was generally relevant, appropriate, timely and effective, though concerns regarding the longer term sustainable impact of the project remains to be seen, though institutional arrangements and attempts to link the outcomes of this project to other KRCS long term programs and partnership arrangements are being undertaken. It was recognized by those interviewed that the KRCS adhered as closely as possible, given the resource and time constraints faced by this project, to the standards set out in Sphere, the Red Cross Code of Conduct, and its own internal quality standards.

Several areas for future focus were identified throughout the evaluation, most notably the importance of strengthened participatory and consultative project design to ensure a solid base for community ownership of interventions. Strengthening of needs assessment processes, baseline data, monitoring and reporting systems are areas for concerted attention in future. Additionally, there is need for KRCS to ensure it is setting realistic, achievable objectives in its short term interventions, looking closely at internal capacity, operational challenges such as security, resources and timeframes. To ensure longer term, sustainable impact of its initiatives, KRCS must develop consistent transition and exit strategies, particularly in its short term emergency response projects, to identify how its interventions will link to other longer term programming to ensure the effects and benefits of project implementation can continue into the future. Lastly, efforts to strengthen information, communication, and coordination, internally as well as with other external stakeholders, are areas identified for attention going forward.

I. INTRODUCTION

The Horn of Africa has increasingly experienced severe climactic conditions over recent years, manifested by alternating cycles of drought (closely associated with La Nina phenomenon) and floods (associated with El-Nino phenomenon). The Arid and Semi Arid Lands (ASAL) areas of Kenya bear the greatest burden where cycles are magnified from the normal fragile environmental and climatic conditions to extreme droughts and food insecurity which take a heavy toll on human, livestock and wildlife populations. In 2011, Kenya experienced a severe drought in its ASAL areas with the hardest hit being Turkana, Marsabit, Mandera, Wajir, Northern Isiolo, Northern Tana River, Moyale, and Southern Kajiado districts. This drought contributed to scarcity of water thus the increase of prevailing conducting environment for transmission of water borne diseases, including cholera.

Cholera outbreaks have been recorded in several parts of Kenya during the past years and often they are associated with drought conditions and poor hygiene and sanitation. Drought conditions compel people to move to places where water and sanitation infrastructure are not available, and they may transmit diseases along the migration routes. Cholera and other water borne diseases occur during rainy seasons that follow droughts due to poor practices and damage of sanitation and water infrastructure.

Driven by conflict and drought, several hundreds, and even up to 1,000 people daily, were reported to be crossing the border from Somalia into Kenya, fueling a cross border spread of cholera into Kenya. Cholera cases were confirmed in August 2011 in the Haghadera camp in Dadaab, compelling the Kenyan Ministry of Public Health and Sanitation (MoPHS) to announce a cholera alert in Northern Kenya, consequently increasing surveillance along the border points due to the potential risk of the importation of the disease into the country through the asylum seekers.

Initial assessments of the situation undertaken by the Kenya Red Cross Society (KRCS) confirmed that Northern and northeastern Kenya, already experiencing the impact of severe drought, food-insecurity and high levels of acute malnutrition among children under-5, were at risk for a significant outbreak of cholera which could lead to high levels of mortality. With the rainy season anticipated to start imminently, there was reasonable expectation that the onset of rains would facilitate the spread of cholera in these regions.

Therefore, a combined preventative and response action was proposed, in order to build resilience and prepare the communities with simple means to prevent and to manage simple forms of diarrhea and cholera, and to provide a solid basis in anticipation of a potentially looming cholera epidemic, contributing both to the hindering of further disease spread, and to saving lives of affected individuals. As such, the KRCS proposed a six month emergency health care project to support existing healthcare facilities, providing them with means to appropriately manage cholera patients, in order to directly reduce cholera related mortality.

As part of its proposed intervention, the KRCS aimed to support the roll out of the Kenya Essential Package for Health (KEPH), which targets six health service delivery levels. Most notably, the KEPH includes the introduction of Level One services that are aimed at empowering Kenyan households and communities to take care of improving their own health and enhance community access to health care

services. Implementation and roll out of the Community Health Strategy is viewed as a significant approach to addressing access to basic primary health services for Kenyans, thus contributing to reversing trends of communicable diseases; including cholera in Kenya. However, the implementation of the Community Health Strategy had been slow to reach some districts, due to various reasons and challenges, including limited funding and resources, lack of capacity, difficulties in harmonizing or sustaining the different models of Community Strategies being implemented by different organizations, lack of consistency in roles and training of community health workers (CHWs), and limited participation of partners in the implementation of the community strategy.

In line with this background, the KRCS emergency health care project was designed to be implemented in the context of the Kenyan Community Health Strategy thus laying out health service organizational infrastructure to combat the key challenges, build on existing Government of Kenya (GoK) policies as well as provide for real opportunity for the up scaling of the community strategy within the targeted areas. This KRCS project was launched within the wider overall drought emergency response, supported by the International Federation of the Red Cross (IFRC), and was designed to be aligned and complement other on going emergency initiatives.

The project initially proposed to benefit populations affected by the 2011 drought in the arid lands of Kenya. The estimated total number of direct beneficiaries was projected to be 629,000 - divided between people receiving health and hygiene education, and patients receiving treatment for cholera / diarrhea and other emergency illnesses. It was expected that a large proportion of the beneficiaries would be children with diarrhea, many of whom were also expected to also be acutely malnourished. In the border area towards Somalia, provision of emergency healthcare was proposed to primarily target vulnerable Somali refugees who had recently crossed the border into Kenya, with the host population also then subsequently benefiting from the services being offered.

The KRCS support to the roll out of the Community Health Strategy proposed to cover 19 community units with training and capacity building for Community Health Workers (CHWs). Each community unit was estimated to cover a population of 5,000 people. Nineteen (19) community units were also proposed to be targeted through the CLTS (Community Led Total Sanitation) program with hygiene and sanitation events. The project also aimed to build the capacity and network of KRCS volunteers to enhance the transmission of health and hygiene messages during social mobilization and sensitization campaigns within the communities to trigger behavior change in disease prevention and health promotion.

Key areas of focus for the interventions were chosen in conjunction with the Ministry of Public Health and Sanitation (MoPHS) in line with the following criteria:

- a) Areas with reported and confirmed recurrent cases of cholera (cholera hot spots).
- b) At risk areas locations neighbouring areas with reported cholera cases and with water scarcity, low sanitation coverage and poor hygiene practices, in particular areas relying on surface water or water from shallow unprotected hand dug wells.
- c) Flood prone areas with displaced populations (and often with low water and sanitation coverage)
- e) Areas with high malnutrition rates heavily affected by prevailing drought.
- f) Areas with high morbidity rates of diarrhea and dysentery

While the original ECHO proposal was designed to address cholera coming from Somalia and boost health care in the transitional border corridor, given the confirmed outbreak of cholera in the Dadaab refugee camp and in response to a request for support by the Ministry of Health (MoH) and UNHCR, KRCS adjusted the original proposed interventions to include provision of assistance for cholera response in Ifo2 Camp. Line listing of the cases in Dadaab and at the end of the outbreak a total of 1,286 cases had been diagnosed, six of which were from host communities living around the refugee camps and one case from Saka in Balambala district. According to surveillance reports cholera hot spots were mapped out with critical focus on the most at risk areas, namely Saka, Tana North, Wajir West and Elwak of Mandera Central districts. As such the interventions were adapted to focus on these areas of the northeast region to contribute to the reduction in the prevalence of acute watery diarrhea (AWD) in the seven districts.

ii. EVALUATION OBJECTIVES

The evaluation examined the impact of the ECHO funded KRCS emergency healthcare operation on the lives of beneficiaries in the affected districts and assessed whether the type of aid delivered was relevant, timely, efficient, effective, coordinated and sustainable to the needs of the target communities in northern and northeastern Kenya. More specifically, the evaluation process sought to answer the following questions and address the following issues:

- **Relevance/appropriateness** – *“The extent to which the objectives of an intervention are consistent with the requirements of the beneficiaries”*.
I.e. were the outlined problems important to the beneficiaries, and was the project design optimally structured to address the outlined problems: a) outbreaks of cholera; b) emergency health needs among Somali refugees in the transition area between the Kenya-Somalia border and the Dadaab refugee camps ?
- **Efficiency** – *“A measure of how economically resources and inputs (funds, expertise, time, etc.) are converted to results”*.
I.e. did the project reduce morbidity and mortality significantly when looking at an overall budget of 1 million Euro ?
- **Effectiveness** – *“The extent to which the objectives were or are expected to be achieved, taking into account their relative importance”*
I.e. did the project meet the indicator targets: Case fatality rates in accordance with WHO / SPHERE standards ?
- **Impact** – *“The positive and negative, primary or secondary, short or long terms effects produced by the intervention, directly or indirectly, intended or unintended”*.
I.e. has the intervention made a difference, vis-a-vis the principle objective of the intervention, either short-lived or long-lived, contributing to reducing morbidity and mortality among populations living in drought and disaster affected areas of Kenya ?
- **Sustainability** – *“The continuation of benefits after the project implementation has ended. The probability of long-term benefits, and the resilience to risk of the benefits over time”*.
I.e. are the activities and the effects of the project likely to continue after external support has been completed ?

In addition, the evaluation considered the following criteria:

- **Connectedness** – *“The need to assure that activities of a short-term emergency nature are carried out in a context that takes longer-term and interconnected problems into account”.*
- **Coherence** – *The need to assess security, developmental, trade and military policies as well as humanitarian policies, to ensure that there is consistency and, in particular, that all policies take into account humanitarian and human rights considerations”.*
- **Coverage** – *“The need to reach major population groups facing life-threatening suffering wherever they are”.*

Certain constraints affected the evaluation, most notably inaccessibility to some of the project sites, in particular the northeast region. As a result not all the affected communities were visited or consulted on the KRCS response, however, the evaluation was able to visit five of the targeted 18 sites in Isiolo and Turkana districts as well as speak to district level representatives, KRCS volunteers and community members to get a better understanding of the scope and impact of the operation.

Other constraints faced during this evaluation were the unavailability and slow provision of relevant documentation and resources for analysis, as well as difficulties interviewing key personnel and stakeholders due to busy schedules and competing priorities. For instance, provision of HMIS reports, coordination meeting minutes, project overview documentation, internal monitoring updates etc were not availed despite repeated requests. Key contacts for external stakeholders to interview, particularly in the northeast region, were not provided. During the consultant’s field site visit to Turkana District the majority of key district stakeholders needing to be interviewed as key informants had left town for planning meetings and were therefore unavailable to provide feedback. Schools in this district were also closed therefore making it difficult to evaluate the SCHEPP and hygiene club interventions, etc. As such, this evaluation was unable to provide the full, comprehensive analysis of the response as originally anticipated.

Lastly, the originally proposed consultancy team envisaged to undertake this evaluation consisted of a three person unit, including a technical health expert from IFRC and a fully dedicated KRCS resource person. This composition was not realized, therefore, the evaluation was conducted by one general emergency response programming independent consultant, without the technical expertise to provide the health sectoral analysis component of the cholera response in Dadaab. Therefore, the evaluation was compromised in terms of technical scope and coverage, and thus focused more generally on the overall efficiency, relevance and sustainability of the health and hygiene knowledge, attitude and practice impacts of the intervention.

III. METHODOLOGY

Based on the ToR (see Annex I), the Evaluation Consultant developed a list of main questions and focus group discussion topics to gather information (see Annex III) from the KRCS national, regional and branch levels and local authorities, beneficiaries, and other stakeholders involved in the response. This evaluation framework was shared for review with KRCS HQ staff as well as the IFRC Health Advisor and M&E Officer for feedback and refinement. The framework was first piloted during the field visit to Isiolo District, then revised and adapted in the subsequent field visit to Turkana. Key informant interviews and

participants of focus group discussions were selected by KRCS field staff. Ethical considerations during field visits were factored into interviews and focus group discussions, with particular regard for the welfare of those involved in and affected by the evaluation.

- An initial briefing session was undertaken with the KRCS HQ in Nairobi to provide an overall understanding of the Emergency Health care project, as well as to review and agree the evaluation workplan.
- Secondary data review and desk research was undertaken by the Evaluation Consultant at her home base in Nairobi and as / when resources were made available throughout the consultancy period.
- Interviews with the KRCS managers at the national headquarters (HQ) and staff of the IFRC delegation in Nairobi.
- Field visit sites to the affected areas in Isiolo and Turkana Districts were conducted from 18 July -1 August.
- Focus group discussions were held with local district authorities, KRCS regional and branch offices, community health workers and KRCS volunteers, and with other community members who were engaged or benefited from the project.
- In-depth interviews were conducted with community health workers, community health extension workers, community health unit management committees, school health club members, and relevant district level authorities.
- Key informant interviews were conducted with the staff of the KRCS, District Ministry of Health, District Public Health Officers, District Education Officials
- Debriefing meetings were held with regional and branch offices prior to the conclusion of each district site visited to discuss outcomes of evaluation and agree key points for report inclusion.
- A debriefing session was held following the site visits with participation from the IFRC and KRCS representatives in order to review process and agree reporting way forward.

IV. MAIN FINDINGS

The evaluation criteria of relevance and appropriateness, effectiveness, efficiency, impact, and sustainability were used whilst examining the objectives of the KRCS emergency healthcare project in Kenya. Additionally, the evaluation also sought to address cross cutting issues of institutional capacity and the extent to which the fundamental concepts of connectedness, coherence and coverage were considered in the design, implementation and monitoring of the response.

Summary of Interventions:

The originally proposed ECHO emergency health care project was designed for a six month period with a budget of 1million EURO, and included the following objectives and results:

Principal objective: Contribute to reducing morbidity and mortality among populations living in drought and disaster affected areas of Kenya.

Result 1: Reduced morbidity and mortality due to cholera.

Result 2: Reduced morbidity and mortality due to health emergencies among refugees en route and host communities in the border areas.

Specific proposed interventions included:

- 1.1 Procurement and distribution of Medical, Water and Sanitation Essential Supplies
- 1.2 Health Promotion, Community sensitization and Support to Social Mobilisation
- 1.3 Training of volunteers and community health workers on cholera interventions
- 2.1 Advocacy, information sharing and coordination at all levels.
- 2.2 Supporting four existing health facilities on emergency primary health care.
- 2.3 Support to referral mechanisms

Please refer to Annex 7 Overview of Interventions for comprehensive comparison of proposed versus achieved results. To briefly summarise site specific achievements, however, with resources allocated to the three targeted operational areas (Isiolo, Turkana, northeast region), the KRCS was able to achieve the following :

In Isiolo District:

The Isiolo District interventions were rolled out in January 2012, three months after the initialization of the project. Feedback from KRCS staff at the regional office indicated this delay was due to a release in funds, however, ECHO approved the project with implementation intended to commence from 1 October 2011 with pre financing available from IFRC. KRCS HQ staff confirm that the delay in implementation was rather the result of prioritization of implementation of activities in other sites. From January 2012, following consultation with local authorities on cholera hotspot areas to target and prioritised interventions, the project focused within Isiolo County in Merti (which has a history of cholera outbreaks, experiences frequent flooding during the rainy season, and has low sanitation coverage and poor hygiene practice), Oldonyiro and Kipsing (both of which have low water and sanitation coverage, poor hygiene practices, and depend on water from shallow unprotected hand dug wells and sand dams).

Reports, interviews, focus group discussions and review of distribution matrixes confirm that in Isiolo District the following was achieved:

- 6 community health units out of a proposed 10 were established reaching a total of 30,688 people
- 5 medical outreach campaigns were conducted for Internally Displaced Persons (IDPs) within Isiolo District targeting over 800 households. As a result of this outreach, 467 patients were treated with basic health care during the exercises, and 700 IDP HHs were provided with water Jeri cans and bars of soap in an effort to improve hygiene conditions in the camps.
- 56 KRCS Volunteers and CHWs were involved in door to door visits of households on a weekly basis targeting 4,327 households for a total a target population of 21,998 people
- One (1) health facility in Merti District is being supported through the construction and handover of a Cholera ward, however, as of 23 July 2012 the status of construction was still at foundation level (challenges and delays in the completion of this activity are addressed in more detail below).
- PHASTER: Two trainings for 56 KRCS volunteers and CHWs on PHASTER were held to assist with community roll out and address preparedness levels

- SHEPP: KRCS worked with 6 schools to train 12 teachers as designated health club patrons on basic hygiene promotion, who then were responsible for establishment of health clubs and outreach to school populations. It is estimated the formation of the 6 health clubs were able to reach a student population of 1,926 pupils. Schools were also provided with IEC materials, hand washing facilities, hygiene promotion kits, and support to inter school competitions promoting hygiene messages through song and dance.
- Production of IEC materials: KRCS provided 150 CHW Log books, 150 CHWs summary registers, 150 CHEW Summary books, three health data chalk boards for disease and health status surveillance, 296 T-shirts, CHW health package kits, and provision of 30 bicycles to CHUs to facilitate movement for most distant communities.
- A 5-day training was conducted for 72 CHC members from the district on roll out and management of the Kenya Community Health Strategy.
- Training was conducted for 112 identified CHWs on: Health Promotion; Disease prevention and control to reduce morbidity, disability and mortality; Expanding family planning, maternal, child and youth services; Hygiene and environmental practices; Care seeking and compliance with treatment and advise; Governance and Management of health services; and Claiming rights.
- Training was conducted for 25 CHEWs from Isiolo District for five days at Isiolo District Hospital
- Monthly meetings for the CHCs in Merti, Oldonyiro and Kipsing were facilitated for three months from April –June to monitor progress.
- Provision of support to social mobilisation exercises in April and May, with printing of a banner and facilitation of allowances for 40 volunteer/CHWs from Isiolo District who assisted medical personnel in administering vitamin A and crowd control. Allowances were also provided for 4 CHEWs who were involved in the exercise in the project sites.

According to key informant interviews with district level health and education authorities, CHEWs and CHWs, the interventions had a notable impact within the targeted communities, with improved health indicators – including child mortality rates - being realized following the outreach activities, improved immunization rates, strengthened referral systems, and improved latrine construction and usage statistics. Those interviewed confirmed there was a marked improvement in hygiene and health practices, and more general awareness within the communities regarding cholera and disease prevention. Visits to CHUs and a brief review of very basic reporting data confirmed a decline in the rates of acute watery diarrhea (AWD) reported over the past six months, as well as a general uptake in number of persons seeking services in the health facilities. Although the District Public Health Officer (DPHO) did not readily have HMIS reports available for review, interviews with CHEWs at the community health unit (CHU) in Oldinyaro revealed a reduction of reported AWD from 50-60 per month at the start of 2012 to less than 10 reported cases a month by the close of the project in June. In Merti District the Community Health Clinic reported a decline in AWD cases from an average of 50 per month in January to 5 reported cases in June. However, KRCS staff interviewed in Isiolo District informed that as no thorough needs assessment or baseline survey was undertaken in Isiolo District in order to establish benchmark indicators, monitoring the impact of change was difficult and more output focused. Again, while HMIS reports were requested by the consultant to confirm and quantify the improvements in health conditions and referrals, these were not made available during the course of this evaluation.

In Isiolo District the CHW trainings were undertaken in February with door to door education campaigns within the communities beginning in March. The short time period for implementation, despite the

three month extension, was deemed not long enough by all interviewed to fully address the proposed outcomes of the project, and therefore the continuation of the interventions remain in question as CHWs activities remain dependent on additional funding and support. It was suggested that continued engagement of the trained KRCS volunteers as CHWs will be sustainable due to the allowance they receive in their KRCS roles, however without dedicated funds for the non-volunteer CHWs their motivation to continue home visits and outreach activities was raised as a concern. To ensure continuation of the interventions initiated through this ECHO funded project, it was suggested that allocation of more funds to strengthen the community units through DHMTs and with KRCS supervision needs to be undertaken. Facilitation of CHWs and CHC meeting allowances also need to be raised in order to ensure their continued involvement.

Similarly, while gratitude and appreciation were noted for the school outreach campaigns, authorities and school officials did raise concern about how to sustain the initiatives without continued dedicated resources and funding, currently not available.

The Isiolo team noted that the flexibility of the ECHO funding allowed for revisions and adaptations to the original proposal which was appreciated and enabled adjustments for changes in reality over the project period, i.e. being able to respond to the needs of the IDP communities displaced by conflict in early 2012, though this was not initially identified as a priority area of intervention. By using an integrated medical outreach approach falling under the wider context of “emergency health”, KRCS in Isiolo were able to assist such vulnerable populations who otherwise would have been neglected.

Challenges experienced in Isiolo District during the implementation of this project included cultural barriers to reaching some populations with hygiene and health promotion, most notably the Moran population of men who live excluded from the targeted communities and were difficult to sensitise. Also noted as a challenge was the short time period for implementation, resulting in rushed and hurried roll out of project activities. Difficult terrain made some areas hard to access, with some target sites being very distant from the KRCS field office thus resulting in far distances having to be traveled for monitoring purposes. Delays in contracting a local construction team for the building of the cholera ward in Merti resulted in the facility not being completed within the project time period though the contracting process for the construction was completed during the last few weeks of the project. Lastly, according to KRCS Isiolo District staff, challenges in processing procurement requests through the KRCS Nairobi HQ led to delays in the provision of supplies at field level. According to the staff and observation of the stock still stored within the office, the hygiene kits and IEC materials were only received at the end of June and had not yet been distributed to the CHWs.

(Please refer to KRCS detailed region end of project reports for more detailed summary of response activities and targeted communities).

In Turkana District:

Similar to the delays in implementation in Isiolo, the Turkana district team began implementation of activities from January 2012 with mobilization of local authorities and community members in order to come to consensus about populations and areas to target. As with Isiolo, KRCS district staff indicated a thorough needs assessment was not undertaken therefore no baseline data was provided other than consultation with district health authorities on cholera-prone hot spot areas to be targeted, although

KRCS HQ staff confirmed that in the design of the project a health facility assessment / mapping resource was referred to for prioritization of facilities and districts to target.

As the Community Health Strategy approach had not previously been introduced in Turkana, the proposed ECHO-supported activities had to be revised to start at a more basic level with initial support for training of District Health Management Teams (DHMTs) in Eldoret. As the DHMTs were not trained in this District prior to this project's implementation, a reallocation of budget lines had to be undertaken, as in the original proposal this activity was not catered for. This reality also then affected implementation of the other proposed activities, such as training of the CHWs which had to be delayed until later in the project period. It should be noted that the training of the DHMTs was achieved by joint efforts of implementing partners in the district who pooled resources together; while KRCS supported the training by allocating funds for allowances, World Vision catered for accommodation and board of participants, while Aphia Plus provided stationery and transport costs for participants to and from the training site in Lodwar.

According to reports, interviews, focus group discussions and meetings with district officials, it was confirmed that in Turkana District this project was able to support:

- Provision of IEC materials, including 470 T shirts and provision of 30 bicycles for two Community Health Units (CHUs) for CHWs having to cover communities with a distance of more than 25kms from the facilities.
- 160 CHWs from the three selected areas in Turkana District were trained on the key components of the Community Health Strategy.
- 57 CHEWs were trained on Community Health Strategy approach, in partnership and with the support of other partners like World vision, Merlin, and UNICEF
- 1 meeting was held in June 2012 for participants from the targeted areas in order to evaluate the progress of the project, assess comprehension of the communities of the new community approach, and facilitate discussion on how to address future challenges.
- 40 KRCS volunteers and CHWs were trained on first aid and primary health care, preparedness and infection risk reduction in times of outbreaks. Following their training the participants were then responsible for developing workplans for their respective sites of operation.
- KRCS facilitated nine social mobilisation sessions and five action / dialogue days at the village levels through community Baraza (public meeting) with the overall objective of creating awareness on the community health strategy approach
- 25 volunteers/CHWs were trained on Community Lead Total Sanitation (CLTs) approach, with an aim of increasing latrine coverage. Three villages were targeted with a result of 70 new latrines constructed.
- 10 teachers from the Districts were trained on SHEPP methodologies, who in turn were then responsible for rolling out that knowledge to their respective schools through formation of health clubs. The training was conducted by the District Public Health Officers (DPHOs) with financial support from this project.
- Hygiene promotion kits were procured and distributed to 2,200 households, including: 550 cartons of bar soap, 216,000 Aqua tabs, 108,000 PUR sachets, 2,200 jerry cans and 2,200 buckets. 30 bicycles were also procured and distributed to CHWs to support facilitation of their daily activities.

- A major cleanup and sensitization campaign was conducted in Lodwar Township and nearby villages with the support and endorsement of local learning institutions, the Ministry of Education, the Ministry of Public Health and Sanitation, KRCS volunteers and school chapters, business people and the communities.

It was noted that due to limited funds allocated for the Turkana District trainings, the budget lines for hygiene promotion campaigns, SHEPP competitions and IEC materials were merged to be able to fully support the DHMT training held in Lodwar.

Those interviewed in Turkana echoed the concern raised in Isiolo District that the project period was too short to fully achieve the proposed outcomes and impact intended. For Turkana in particular, there were notable challenges to implementation due to the severity of the drought and food insecurity in the district, which affected roll out of activities in the schools as during this time period some of the targeted education institutions were closed as a result of the emergency, while others experienced highly inconsistent attendance. As a result of other emergency projects being implemented and competing priorities, the general effectiveness and impact of the project in this District was thus affected as other emergency interventions were prioritised in order to respond to the most urgent needs of the drought affected populations, thereby delaying implementation of some of these ECHO funded activities.

Other challenges and constraints faced in Turkana included difficulties reaching primarily pastoralist communities, insecurity, difficult terrain and hard to access areas, cultural challenges such as high aid dependency, low literacy rates exacerbated by training materials not being adapted for the local context, and a lack of clear discussion and direction on how to phase / transition out once the project period concluded.

In Northeast Region:

It should be noted that the evaluation of interventions in Northeast Region relied solely on KRCS reports and interviews with three key staff members involved in the project's implementation, as a site visit to the region was not possible due to insecurity. Despite repeated requests to KRCS HQ for contacts of other key stakeholders and district authorities to interview, as well as district coordination meeting minutes, these details were not provided during the course of the evaluation period and thus could not be factored into the analysis of the interventions.

According to KRCS staff and interim / end of project reports from the region, the original design of the ECHO project was developed for the northeast region in consultation with the provincial Director of Public Health and Sanitation as well as the five DHMTs with an aim to: (1) immediately contain the cholera outbreak, and (2) introduce sustainable interventions to strengthen the linkages between health services and communities. Intermediate and final end of project reports indicate the following was achieved:

- Support to the establishment of nine CHUs including trainings for their assigned CHEWs and CHWs
- Provision of IEC materials, including 205 T-shirts, 2,000 posters and 2,030 brochures with hygiene promotion messages encouraging the use of latrines, hand washing at

critical moments, water treatment and prevention of hygiene related diseases especially cholera.

- Provision of seven interagency emergency health kits (IEHK) as well as three cholera kits in Ifo2 Camp in Dadaab. The cholera kits included protective gear, disinfectants, detergents, IV rehydration and ORS infusions, and antibiotics for treatment per WHO guidelines and standards, each providing for treatment for up to 1,000 persons for 3 months.
- Support to three health facilities in Dadaab refugee camp to respond to and manage the cholera outbreak, including provision of medical supplies. Out of the 1,286 confirmed cholera cases, only three deaths were reported thus a Case Fatality Rate (CFR) of <0.3%.
- Chlorination of 158 shallow wells in Mandera Central in coordination with the DPHO, as well as mapping of water sources in refugee integration areas.
- Deployment of medical personnel, including surgeons, nurses, medical officers, drug supplies and hospital equipment to Elwak and Wajir district hospital following escalating conflict in the area.
- Medical outreach to communities including treatment of common ailments, nutritional screening, immunization and referral of cases to MoH facilities.
- Establishment of 9 CHCs with a total of 108 CHC members trained, as well as support to seven CHEWs with training and logistics to carry out their supervisory roles, including the provision of 30 bicycles, allowances and facilitation of monthly review meetings.
- Formation and training for nine (out of an originally proposed 12) CHUs, with a total of 360 CHWs trained on the community health strategy approach and hygiene promotion.

- Provision of support to CHEWS and DHMTs in the form of refreshments and logistics during meetings, as well as transport and allowances for the CHEWs during field supervision meetings. In total 42 field visits were conducted by the CHEWs, of which 14 were accompanied by DHMT members in their respective districts.
- Monthly meetings were facilitated from March-June 2012 for the CHCs in Marantu and Chewele in Tana North district, Saka in Balambala, Eldas and Elenur in Wajir North and Elwak in Mandera Central, during which feedback was provided by the CHWs on hygiene education and monthly diarrhea case loads at HH level in efforts to strengthen cholera and AWD surveillance at community level.

- Training of trainers (ToT) for 41 participants on PHAST for further roll out to 12 communities. It is estimated this activity was thus able to reach a total of 4,032 HHs (24,193 people).
- Hygiene and sanitation campaigns organised by KRCS volunteers with a focus on: basic precautions on infection control at CTCs, Case Management (administering of ORS), water quality/treatment with PUR, Aqua tabs and water guard, Infection prevention, and basic hygiene promotion. Nine sanitation days/events were organized reaching approximately 13,500 people with hygiene messages.
- 10 teachers from 10 primary schools were trained on SHEPP and installed as health patrons in their schools to promote good hygiene practices amongst student populations. It is estimated that a total of 2,000 children were reached with hygiene messages and provided with health related items such as nail cutters, tooth brushes and tooth paste, sanitary towels, under garments and soap
- Two quarterly meetings were held with DHMTs in Mandera Central, Wajir and Balambala districts. In the second meeting held in June 2012 deliberations on an exit strategy were held for agreement on way forward as the ECHO project funding came to an end.

While KRCS originally intended to support the rehabilitation / construction of a health facility in Garissa, due to the short time period of the project and constraints in securing contractors to undertake the work, this activity was revised and instead KRCS utilized the budget line to procure medical supplies for health facilities. This was within the overall approach of ensuring that health facilities were able to respond to cholera outbreaks and other health emergencies within their catchment populations and therefore still fell within the overall objective of the project proposal.

Interviews with KRCS staff indicated that this project has provided a solid foundation for the community health strategy to continue, with notable changes in community health practices already witnessed as a result of this intervention, including improved hygiene and health knowledge and practices, increased latrine usage, and improvements in behavior and attitudes within the communities. In the region there has been a reduction in the number of cases of AWD, according to provincial morbidity data and reports. Meanwhile, in Dadaab there has also been a marked improvement in malnutrition rates: in October 2011 GAM rates were reported at 38.3% with SAM rates reported to be 18.8%. By March 2012 these rates had dropped to 13.1% for GAM and 4.4% for SAM. Whether that is a direct result of this particular project or the combined efforts of inter agency health and nutrition interventions has not been verified.

Challenges experienced during implementation of this project in the northeast region included once again the lack of solid needs assessment information for baseline data (except for reports provided within Dadaab camp and by health officials in Tana). Project staff confirmed they relied on consultation with district authorities and health facility assessment /mapping to identify priority areas for targeting. Other challenges noted were difficult terrain and inaccessibility to some areas, low literacy levels within the targeted communities thus making selection of qualified CHWs difficult, cultural taboos which had to be overcome in order to ensure health messaging was accepted by the communities (such as religious beliefs and practices, sharing of food and use of communal plates, lack of comprehension of the connection linking disease to water), as well as inaccuracy in initial budgeting for supplies, leading to gaps in funding for activities which then had to be revised and adjusted downward throughout implementation. For example, the original budget proposed training of 12 CHUs with 50 CHWs each, however, in reality those training lines ended up covering costs for only 9 CHUs of 40 CHWs. Therefore,

the actual number of beneficiaries reached for this particular intervention was lower than anticipated. However, on the whole, the project was able to reach a significant higher number of total beneficiaries than originally proposed (initial target population of 629,000 but an estimated total cumulative number reached of 999,205).

The challenges and obstacles experienced trying to implement the construction / rehabilitation activities of the health facility in northeast region indicated an overly ambitious plan for an initially designed short term six month emergency response project. Lastly, KRCS staff from northeast region indicated that the lack of a clear and agreed upon strategy for phasing out at the end of the project period was a weakness in the initial project design. While KRCS are proactively working to identify longer term programmes to which this ECHO project can be linked, field staff interviewed indicated it would have been preferable for this to have been considered and developed from the onset of the project.

Relevance and Appropriateness of Response

Feedback from those interviewed, notably local district health and education officials, the KRCS HQ, branch and regional staff, KRCS volunteers and CHEWs/CHWs indicated the emergency health project was relevant and appropriate, informed by government plans for the community health strategy approach, and included active community participation.

It was noted in all three districts, however, that there was a recognised lack of needs assessment processes undertaken and baseline data to guide the implementation and monitoring of the project. The basic assessment information referred to for the design of the project relied on provincial and regional data already in existence, a mapping of health facilities, and consultation with district officials on which cholera-prone areas to target for implementation of activities.

There is an opportunity for the KRCS to discuss and agree internally as well as with district partners the sources of information to be collected and used during future design of projects, in order to establish stronger preparedness measures and consistent sources of information to be used and analysed in the development of future interventions. As was noted in the districts by those interviewed, rather than being initiated at field level based on specific area needs, the project was introduced in two of the three targeted areas three months after its approval by ECHO, therefore, the lack of community and district level engagement in the design of the interventions based on actual needs assessed in the field is an area to be considered and addressed going forward. It was articulated in several FGDs and key informant interviews that this level of consultation and consensus was missing which could have preemptively addressed some of the challenges encountered during implementation.

The KRCS attempt to link its emergency health interventions to the GoK's community health strategy was recognized by district officials interviewed as a necessary and appreciated approach, thereby building the capacity of level one community health structures in districts sorely lacking in capacity and resources. Interviews with CHCs, CHUs, CHEWs and CHWs confirmed they felt the project provided much needed support for communities otherwise neglected in the ASAL areas of northern Kenya, and were grateful for the assistance provided and improved access to health services. Within the wider context of the drought emergency experienced in these areas, this project was considered to provide a missing focus on neglected health issues and address community level resilience and preparedness in

order to prevent and respond to health crises in the future. As the project was aligned with other concurrent drought project and activities, the district and regional offices were able to maximize resources already in place and coordinate response efforts.

The three areas targeted in the northern ASAL regions all have experienced cholera outbreaks in the recent past, therefore, the selection of these particular areas to focus interventions was noted as highly appropriate. As indicated above, the flexibility of the project design allowed for adaptations to proposed interventions for area-specific realities, therefore KRCS were able to adjust the project to meet the evolving emergency health realities faced in the field as situations changed over time (e.g. provision of assistance to IDPs in Isiolo District not specifically targeted in the initial project design; support to the cholera response in Ifo2 Camp in Dadaab). As such, these revised interventions still fell within the wider proposed objective of responding to cholera and other related health emergencies.

While the relevance and appropriateness of the project was generally acknowledged, there were instances where notable gaps and shortfalls in the project design were highlighted. For example, the proposed construction and rehabilitation of health units (in Garissa and in Merti) were not necessarily appropriate for such a short term emergency response. While support to health infrastructure is definitely needed in these areas, such proposed interventions were overly ambitious given the scope and timeframe of this particular project. As a result, the proposed Garissa construction activity was abandoned, with those budget lines revised for the procurement of medical supplies instead. Meanwhile in Merti in Isiolo District, the construction of the cholera ward for the CHU remained at foundation level as of end July, with an estimated completion and handover date not expected until December 2012, well beyond the project period's conclusion. (please refer to Annex 8 for updated status of cholera ward construction per KRCS at mid August).

Additionally, given the severity of the drought in some sites (i.e. Turkana District) and the capacity challenges faced in specific areas, some of the proposed activities were not entirely relevant for their particular realities. For instance, rolling out of SHEPP activities in Turkana was hindered due to school closures, hand washing and hygiene campaigns were undertaken at schools with no water sources, awareness raising on the use of sanitary towels was undertaken with girls who were not provided any nor had access or resources to purchase on their own. Also noted was the need for the adaptation of training materials for local communities in order to make them more culturally appropriate and relevant. The Community Health Strategy training manual was considered too daunting for the CHEWs and CHWs trained in Turkana, and given its standardized content and lack of local cultural context, the participants felt detached from the information they were receiving and were unable to identify how the health messages and information related to or were relevant for their communities.

Similarly, in Isiolo District, community awareness and promotion was undertaken on the importance and encouragement of latrine construction, however, communities were initially not provided with the appropriate tools to be able to dig pit latrines in such rocky terrain until adjustments to the project were made to provide these. Longer term implications of latrine construction were also not considered, for instance, where the communities and/or HHs should strategically locate the latrines, or what should be done once the pits were full.

Considering the vast needs of the affected households and communities in these massive geographical ASAL areas which continue to be affected by recurrent drought and emergencies, a refinement of

activities in this particular project could have been tailored to have greater impact with less proposed interventions. Rather than trying to address so many different areas in all three districts, the project could have been designed to concentrate on the most relevant, pressing needs in each of the three target areas, with a focus on their current realities and circumstances at the time of project design.

Effectiveness of the response

The purpose of the proposed emergency health care project was to provide assistance to targeted districts to prepare and respond to outbreaks of cholera and other emergency health issues, as well as to provide emergency healthcare for Somali refugees in the transition areas between the Kenya and Somalia border and the Dadaab refugee camps. The overall aim of the project was to contribute to a reduction in morbidity and mortality due to cholera, AWD and other hygiene related diseases amongst populations living in drought and disaster affected areas of northern Kenya. The original proposal was revised and adapted to respond to changing needs throughout the period of implementation, including the provision of cholera response assistance within Ifo2 Camp in Dadaab, though all interventions undertaken did fall under the wider scope of emergency health care.

In support of the GoK essential health package, the project supported the roll out of the community health strategy and build the capacity of CHUs, CHCs, CHEWs, CHWs and DHMTs to prevent and respond to health crises in future. To this extent, the implemented activities were effective and did achieve their primary purpose of addressing some, though not all, of emergency healthcare needs in the targeted areas.

With a budget of 1million EURO and an original timeframe of six months (ultimately extended an additional three months through June2012), the KRCS was able to provide relatively effective support in order to respond to the Dadaab cholera outbreak, build the capacity of community health structures, increase awareness of good hygiene practices within communities, and establish a solid foundation of community health networks on which to build in future projects. Taking this community based approach was repeatedly recognised as the most effective way to address cholera prevention in the future, as well as improve outreach to these often neglected communities on improved basic health practices.

The utilisation of KRCS volunteers in the implementation of activities, and including them in the training of CHWs, was noted as an effective means for ensuring continuity as these persons are considered strong, reputable members of the community, were nominated by their own communities, have solid ties to the areas therefore are more likely to continue with activities once the project concluded. In addition, the coordination with local district authorities on the training and support to other CHWs / CHEWs was viewed as an effective way to ensure the local transfer of knowledge which can continue to be built upon through future interventions. Interviews with key informants, focus group discussions and review of reports indicated a strengthened disease surveillance system now in place, with greater awareness and community capacity to address early detection of emergency health issues, and consistent reporting and referral systems now established.

It was recognised by several stakeholders interviewed, including district officials and community members, that credit is due to KRCS' capable field staff who were directly involved with field implementation for the level of effectiveness achieved despite the many challenges and delays. Noted were the strong coordination and connections with relevant local authorities, as well as the excellent

motivation and commitment of staff and volunteers to achieve as much as possible given the time and resource constraints. It was acknowledged that there were a few coordination obstacles at district level with other implementing agencies and partners over scheduling conflicts and competing priorities within the overall drought emergency response, however, implementation was generally viewed as being smooth, coordinated and effective.

That being said, the delays in the start of the implementation of the project did impact the overall effectiveness of the project, despite the three month extension granted by ECHO. Proposed trainings of CHEWs / CHWs did not take place in some areas until the last months of the project, therefore, their ability to actually perform their duties and undertake their roles within the communities prior to the project's completion did affect the effectiveness of the interventions. Similarly, delays in the procurement process resulted in some supplies and resources not being delivered until the end of the project, therefore, in Isiolo District for example the CHWs had not yet received the community health kits or the IEC materials for awareness raising. In Turkana district the status of the unestablished, untrained DHMTs had a ripple effect on the roll out of all other activities, delaying the ultimate outreach to targeted communities. Additionally it was noted that tools and reporting resources for the CHWs arrived only in August 2012, therefore, were not able to be used within the actual project period.

All stakeholders interviewed and consulted echoed the concern that the project period was simply too short to ensure anticipated results, and the longer term effectiveness and impact of the project remains to be seen. A great deal will depend on the government and communities' ability to source other funds and support, as well as KRCS' ability to link this project to its future interventions to ensure continuity of impact. Without a longer term transition / phase out strategy agreed upon and in place the future of the CHUs remains unclear. This project could have been more effective had it been clearly linked from the onset (or throughout the earlier months of implementation) with a direct tie into longer- term programming or more development oriented projects. It is acknowledged that KRCS are still proactively trying to establish those linkages, and efforts remain on- going to link this initial short term emergency intervention to longer term programs as well as other local stakeholders' activities. Please refer to sustainability section below for more details regarding those efforts.

Efficiency of the response

When reviewing the efficiency of the project, it must be stated that it is not really possible within the scope of this evaluation to determine if the six month project ultimately reduced morbidity and mortality rates significantly. While there were reports from Dadaab on the effects of its cholera response and CFR, as well as a decline in all three areas for AWD cases, improved immunization rates, strengthened referral systems and an uptake in cases seen at CHUs, it is not clear if these outcomes are a direct result of this particular project's interventions or a result of combined inter agency emergency programming. The delay in implementation of the KRCS project in all three areas was noted as impacting the overall efficiency of the emergency health care project, as several activities were not able to be rolled out until the end of the project period. Thus, though CHUs in Isiolo District might have recorded declines in AWD cases from January-June, as the CHWs only began their community outreach activities in March, it is not really possible to credit this project with that outcome. Similarly, while Turkana District has not experienced a cholera outbreak this year, given the delay in conducting the trainings for CHEWs/CHWs, obstacles experienced for SHEPP interventions due to school closures, and late roll out of

community sensitisation campaigns due to late availability of supplies and resources, it would be overly optimistic to declare cholera was prevented as a result of this project's activities.

In addition, it was noted in all three project areas that delays in procurement processes hindered the supply of resources to the field which resulted in materials and supplies not being delivered to field sites within the actual implementation period. The requirement for all procurement over a certain budget amount needing to be processed at HQ in Nairobi led to several challenges within the field. It was noted that given these obstacles, the regional offices were finally authorised to begin local procurement in order to secure resources within the project's implementation period.

While the KRCS field teams worked efficiently with the available resources on hand, it was acknowledged the short time frame and hurried nature of this particular response made it challenging for the team to achieve the efficiency of operations for which they strived.

One of the most efficient aspects of this response was definitely the mobilisation and use of the KRCS volunteers. The KRCS volunteers were enthusiastic community members with diversified backgrounds whose skills and contributions were mobilised for outreach activities directly benefiting the communities in which they are based. The volunteers who were targeted also as CHWs confirmed they had received training on the community health strategy, basic health care, hygiene promotion, and PHASTER/CLTS, were grateful for the skills developed and committed to continuing in their roles. However, it was emphasized that there is a need for further, continual training to strengthen their skills to respond to future health emergencies. Additional trainings proposed included more skills development on basic health care surveillance and treatment, expanded trainings on health promotion techniques, trainings for Community Health Committees on management of CHUs, as well as tailored trainings for the targeting of hard to reach populations (such as the Moran in Isiolo).

An additional aspect of this project noted as a concern by several stakeholders interviewed was the lack of a consistent monitoring and evaluation system in order to assess progress throughout the project cycle. The lack of a thorough needs assessment to provide baseline data hindered the ability of field staff to monitor progress against indicators. While KRCS staff members indicated they undertook regular monitoring of activities within the communities as well as joint monitoring with local officials and authorities, others interviewed indicated such M&E efforts were inconsistent from site to site, not always consultative and participatory, and provided little opportunity for community feedback. One joint ECHO-IFRC monitoring mission was undertaken to Isiolo District in March, however, given the delay in implementation of activities there was not much monitoring which could be undertaken, however technical guidance and advice was provided by the M&E mission on how to improve and adjust activities for specific site circumstances (such as approval to provide appropriate tools to the community for the construction of latrines).

District officials interviewed indicated they would have preferred more frequent and more joint monitoring activities to be undertaken. It was noted as a concern that in some cases KRCS by-passed district level officials, going instead directly to the field and communities without consistently consulting or updating the relevant authorities.

In the more accessible sites, communities confirmed that KRCS staff undertook monitoring consistently in order to check progress, receive feedback from CHCs, and advise on ways to improve efficiency of

community outreach activities. In some of the more distant, hard to reach sites (such as Merti in Isiolo), interviews with CHU representatives and community focus group discussions indicated there was minimal monitoring undertaken by KRCS, a crucial gap in the project management cycle especially considering the difficulties experienced and delays in construction of the cholera ward. However, according to KRCS HQ monitoring visits were adequate and in line with implementation progress of activities. Given the status of the progress on construction, the delays experienced could have been more effectively communicated onwards in order for KRCS HQ and IFRC to proactively address communication with the donor and support contingency planning for next steps. It was also raised as a concern by the CHC in Merti that when KRCS did undertake a monitoring visit, they consulted only with the district management official of the health clinic, and the CHC members felt disengaged and were often unaware of the status of the project. As such, there were very high expectations of the project which were not met as the project was not fully explained or communicated to the communities themselves.

In Turkana District, monitoring was reportedly undertaken at various levels with involvement from project staff, district officials, the branch coordinator and regional staff. Additionally, KRCS HQ confirmed the Turkana team received additional support from a HQ finance officer. Interviews with Turkana staff, district officials and community members however indicated they had not received a programmatic monitoring visit from HQ during the implementation of the project period, which would have been helpful in order to assist and provide guidance on how to overcome and address the challenges being encountered during implementation.

In Northeast Region the monitoring aspect seemingly ran more consistently, with two monitoring visits being undertaken by the Regional Health Officer in Garissa, DHMTs, joint monitoring missions undertaken with the district MoPHS and one visit from the Program Manager at HQ in Nairobi. Due to insecurity concerns it was not possible for an M&E technical support visit to be made by IFRC.

As can be expected in any emergency response project, there were several internal and external factors that affected the overall efficiency of the operation:

1. Poor infrastructure, notably severely damaged roads and treacherous terrain conditions made access to sites difficult.
2. The general lack of capacity within the DHMTs and district health authorities to lead and coordinate the response efforts was also highlighted as an external challenge that affected the overall efficiency of the operation.
3. Within the KRCS, the delay in mobilization and implementation of activities at field level in Isiolo and Turkana affected the organisation's ability to ensure timely roll out of activities.
4. Lastly, the lack of a longer term strategy linking this response with other longer term interventions affected the overall efficiency of this particular project. The CHUs are still waiting for a decision and guidance on how to continue their community outreach activities, and without secured resources to continue supporting CHWs the communities expressed concern over sustained engagement and motivation to continue, given their need to look for alternate sources of income and livelihood.

Lastly, a review of the budget versus actual costs revealed that the original budgeting did not accurately reflect the requirements for activities in the field, with several variations having to be made throughout

the project to address the realities of needs and capacity. This therefore resulted in several delays in implementation, as regional offices had to await approval of budget revisions from Nairobi level HQ.

Timeliness

Within the given parameters and considering the delayed nature of the implementation of some activities, the emergency health care project was generally considered timely. The immediate response provided by KRCS to the cholera outbreak in Dadaab was noted, and their on site presence to deliver assistance given the insecurity and conflict experienced in the area was indicated to be a significant factor. The mobilization and roll out of activities in the regions to coincide with prevention activities was viewed to be timely considering the dry spell before the onset of the rainy season and previous experience of cholera outbreaks in the targeted areas.

The project was also considered timely in that it complemented other concurrent emergency drought programming thus had the ability to coordinate and align activities with other responses. Most notably, district officials interviewed confirmed the project coincided in a timely manner with the roll out of the community health strategy approach and assisted in ensuring the ASAL areas were supported in the wider overall KEPH.

However, as has been noted throughout this report, the short time period for project implementation and delays in activation of activities in some targeted areas were acknowledged repeatedly as a challenge. It was suggested by all interviewed that a longer project period, a minimum of one year, would have been recommended in order to achieve more and ensure longer term impact and effectiveness of interventions.

Impact

As indicated in the previous sections, the longer term impact of this project's interventions remains yet to be seen, as the delays in implementation of activities resulted in several of the proposed interventions only taking place towards the conclusion of the project. The support provided by KRCS to the roll out of the community health strategy was seen as a positive step to ensuring these efforts can continue to be built upon, with notable changes already being recognised within communities.

The increased construction and use of latrines, improved hygiene and health practices, the use of treated water and the overall improvement of health in the communities were all noted as significant improvements achieved through the implementation of this project. However, whether these improvements will continue and have a lasting impact in the targeted communities will require longer term monitoring to assess continuity of the interventions and sustained change in knowledge, attitudes and practices.

It was noted in several interviews that the community approach undertaken in the implementation of this project is the greatest factor in ensuring lasting impact, as this helped to facilitate a sense of responsibility and ownership of the initiative within the communities themselves. As this project introduced fairly new concepts to the communities, however, it will take time for practices such as improved hygiene and health behaviour to take root and become engrained in community culture. The training and capacity building of the CHWs and KRCS volunteers was seen to be a positive way to ensure the initiatives started with this project will continue into the future, with these resource persons within

the communities able to consistently reinforce messages and promote improved health and hygiene practices going forward. The capacity building component of this project was also viewed to be integral to strengthening the resilience of communities to withstand drought emergencies in the future, enhance early warning / early action systems and take responsibility for their communities' healthcare.

The project was also seen to have made significant improvement to networking systems through the community outreach activities, in particular the facilitation of CHW household visits. The communities are now more aware of their rights and responsibilities with regards to health care, and thus know how, where and when to access services. This is expected to lead to reduced risk of communicable diseases and cholera outbreaks, however, again, the longer term impact of this can only be validated in future through continued monitoring.

Sustainability

The ECHO funded emergency health care project aimed at improving level of preparedness and response by addressing immediate humanitarian needs associated with outbreak of cholera and other diseases. The planned activities were designed with an emergency focus however they were intended to leave a longer term impact at individual, household, community and institutional levels.

Awareness and knowledge levels of the target communities were improved through the implementation of the project, which will help the communities to improve their hygiene practices and use the new knowledge in future to reduce the level of risk of disease outbreaks. The capacity building of the KRCS volunteers who are based in the target communities will remain an asset and improve community based capacities to combat cholera in similar future context. In addition, the provision of basic supplies to MoPHS health facilities, as well as provision of CHW/volunteers kits were intended to boost the local capacities at least for the medium term.

Coordination efforts of the project team helped to ensure close synchronization with the Kenya Cholera Taskforce, district steering groups, watsan, education and health sector fora, and other relevant bodies. The implementation of the project activities was also coordinated with the MOPHS at various levels to support local capacities in a number of health facilities for primary emergency health care, which should prove useful now that the project has concluded in preparation of response in similar future emergencies. By taking this approach the KRCS attempted to ensure transfer of knowledge and information to relevant stakeholders and within existing mechanisms that will remain in place long after this project has ended.

However, as was indicated repeatedly through interviews and FGDs in every region, the lack of a longer term exit / transition strategy to ensure continued support to the CHUs is a significant factor in ensuring the project's longer term sustainable impact and community resilience over time. Unless monitoring and continued support is identified and provided to the targeted communities, even remotely, the communities may not be able to fully realise continuation of plans due to a lack of capacity, essential materials, resources and equipment. Given the lack of capacity and resources in these ASAL areas, continued support will be required to ensure the community health foundations established through this project have a means of progressing into the future.

The KRCS is undertaking proactive steps to link these interventions with other initiatives and to other humanitarian agencies' projects, which should be recognised. In Isiolo District a sustainability proposal was developed in June by project staff in consultation with the DPHO and DMOH linking this intervention with a 45 month Water Sanitation Hygiene Community Project for Drought Prone Arid and Semi Arid Lands. In Merti, eight of the CHWs trained will continue to be supported by Action Contre la Faim (ACF) in the implementation of their nutrition projects. Within Isiolo and Turkana Districts coordination can be undertaken with other agencies implementing health and watsan projects, such as World Vision, Childfund, and Merlin, to see how trained CHWs can contribute to and be absorbed within their projects. In northeast region discussions remain on going about how the MoPHS as lead agency can absorb the project's initiatives to ensure continuity. The northeast region team is also attempting to tie this project into other KRCS funded initiatives, including an integrated food security project, a maternal child health project (EU funded project for three years), and an integrated watsan and livelihood project. There is also opportunity for the KRCS to provide continued support through a newly proposed IFRC DRR project currently under consideration for ECHO funding, which would allow for enhanced capacity building of the currently trained CHWs and increase emergency health surge capacity mechanisms in Turkana District.

The efforts to ensure continued sustainability of this emergency health project are commendable, however, it would have been preferable for such considerations to be addressed during the design and implementation of the project period to guarantee a smooth transition and phasing out could be achieved prior to project completion.

CONCLUSIONS AND RECOMMENDATIONS for WAY FORWARD

The KRCS emergency health care response was an ambitious project for an initially proposed six month time period, which as a result experienced challenges during its implementation. However, significant achievements were realized as a result of this project, most notably the much needed assistance to the cholera response in Dadaab, the support to the GoK's community health strategy which helped to finally kick start the approach in neglected Districts, the capacity building of communities to take responsibility for their own health, and the distribution of much needed supplies and resources to health facilities. In particular, the support provided by KRCS for the roll out of the community health strategy was seen as a positive step to ensuring these efforts can continue to be built upon, with notable changes and improved health and hygiene practices already being recognised within the targeted communities.

Despite the challenges raised throughout this report, the staff and volunteers of the KRCS at national level in Nairobi and at the regional and branch levels in Isiolo, Turkana and in the Northeast Region demonstrated high levels of integrity, professionalism, motivation and commitment to ensure they could achieve as much as possible given the timing and capacity constraints. It is commendable that the KRCS are proactively trying to address the different humanitarian needs of their communities, in particular the most vulnerable, marginalized and neglected communities in the ASAL areas. However, it was noted as a concern by staff interviewed that perhaps the KRCS are trying to address too much and cover too many projects outside their current mandate and capacity, thereby spreading themselves too thin which in turn affects their overall efficiency. It is tempting for agencies to want to respond to every humanitarian crisis, however, it is necessary for the KRCS to assess its own capacity, resources and mandate in order to concentrate its efforts on what it can realistically achieve, recognizing that there

are other partners and agencies who are also capable and perhaps better positioned to respond in some areas.

A major component of this evaluation was the interviews conducted with the officials from the district level, field staff, and, most importantly, the communities themselves. Their positive feedback, their requests for continued and increased KRCS support, and their articulated admiration for KRCS's staff and volunteers all underline that KRCS operated admirably in their response. Feedback from these stakeholders, as well as personal inspections of records, reports, and operating systems support the findings that KRCS did its utmost given the constraints and challenges to implement a quality project which, it is hoped, will continue to have a lasting impact into the future.

Recommendations:

1. Project Design - The KRCS proposed its ECHO-funded emergency health care project in September 2011 following review of existing health data and consultation with district MoPHS authorities on which cholera prone areas to target its interventions. However, according to interviews and FGDs other relevant district officials and communities in the targeted areas were not consulted on the design of the project, but rather were informed of its existence months after the project was officially approved. This top down rather than bottom up / grass roots approach was noted as a concern by several stakeholders, and has the potential to ultimately affect the longer term sustainability of the project as some communities have failed to take on a sense of ownership for the initiatives. It is recommended that a more consultative, participatory approach with the communities themselves be undertaken in the design of future projects, in order that the proposed interventions reflect the reality of the situation in the field and are not only relevant but also culturally appropriate for the targeted communities.

2. Needs assessment / baseline data: In line with the above, the KRCS assessment and data which fed into the design of this project relied on existing health data from districts and consultation with some district officials on which cholera prone areas to target interventions. Given the three months from the time of approval to the time of actual implementation in Isiolo and Turkana, a more comprehensive needs assessment could have been undertaken in order for field staff to have solid benchmark indicators for monitoring and reporting progress. This is an area for KRCS to address going forward, in order to strengthen its team's ability not only to gather the required data (thus knowing what data needs to be generated), but also the ability to then analyse the information in order for programmes to address different needs of different communities and in different sectors. There is therefore opportunity for KRCS to strengthen the timeliness of data collection and information generation going forward.

3. Monitoring and Evaluation: As a result of the lack of baseline data, KRCS staff indicated they experienced challenges undertaking thorough monitoring of activities in order to assess progress and achieved impacts. Thus, monitoring of activities focused primarily on outputs as opposed to outcomes and longer term impact. Additionally, as highlighted above, monitoring systems varied from site to site, with some joint monitoring visits with district officials being undertaken, while in other target areas those interviewed indicated they did not receive the same consistency of approach. Some communities felt they were not consulted and were unaware of the status of the project, or how to contact or provide feedback to KRCS. It is recommended for the KRCS to review and strengthen its current M&E

systems to standardize how monitoring will be handled going forward, in order to ensure its monitoring procedures are consistent. While additional technical M&E support from IFRC would also be helpful, it is recognized that IFRC staff are limited in their ability to provide field support in insecure areas by internal regulations and policies concerning travel to the field.

4. Information and Communication: Throughout the project period, the relay of information to the relevant stakeholders on status of progress and the flow of communication channels appears to have been inconsistent. While field staff indicated their reporting lines to KRCS HQ operated smoothly, review of communications and reports indicate essential information missing and delays in submission of progress updates. For example, in July 2012 when this evaluation consultancy commenced, the only reports available for review were the interim project reports from the three regions, all still in draft state, all still missing crucial information, a month after the project had concluded. Additionally, onward information and communication flow to IFRC regarding status of the project in order to liaise with ECHO was inconsistent and not as proactive as it could have been, from both sides. The status of the cholera ward in Merti, and the fact that the technical team at IFRC were not aware of the challenges and delays being experienced in order to communicate that on to the donor, is just one example of vital information which could have been communicated in a more timely, proactive manner. The donor also indicated that during changes to the original project proposal, some decisions were taken by KRCS without thorough consultation, rather ECHO was informed of decisions about revisions to activities after they had been made and acted upon. It is therefore recommended that the KRCS review its internal and external communication systems and information flow, in order to ensure in future that all key stakeholders are kept informed and engaged throughout the project cycle implementation.

5. **Realistic expectations:** As mentioned above, there was concern noted at several levels, including with KRCS field staff, that the agency is trying to address too much and cover too many projects outside their current mandate and capacity. The KRCS must assess and identify its own strengths, weaknesses, capacity and limitations, and plan realistic projects which are achievable in the proposed timeframes. While it is noble that the KRCS wanted to assist with the construction and rehabilitation of health facilities, this was clearly not achievable within the scope and timing of this particular project, nor did KRCS have the technical capacity in the field to oversee and supervise construction of such facilities within the proposed time period. KRCS' approach of working through and with communities and its volunteer networks is its greatest comparative advantage, in order to manage and respond to disasters, improve access to health and social services, build community resilience and strengthen disaster risk reduction efforts. Rather than overstretch itself, it is recommended that the KRCS focus its efforts on its core operational strengths, what is within its mandate, and what it can realistically achieve.

6. Sustainability and Exit / Transition Strategy: As was highlighted consistently throughout this evaluation, the lack of a longer term exit / transition strategy to ensure sustained and lasting impact of this project was a significant gap missing in the project design. While efforts are on-going to try to link the interventions of the emergency health care project to other initiatives and longer term projects, it has not yet been guaranteed that the effects and impact of this project will continue. While this project has set a strong foundation, particularly for the community health strategy, to continue to be built upon, without concerted, dedicated continued support to the established structures the sustainability of this project's efforts is at risk. It is therefore recommended that in future design of projects, timely

discussion and consultation is proactively undertaken by KRCS to identify how and to whom a handover of responsibility will be handled, in order to ensure a smooth transition strategy is in place at the conclusion of such interventions.

7. Coordination Mechanisms: While generally acknowledged that coordination of KRCS with other stakeholders was undertaken to ensure efficiency of response operations, it was noted that this remains an area for enhanced efforts in future. While KRCS does participate in district, regional and national level coordination fora, it was noted in field interviews that other agencies and stakeholders were unaware of KRCS plans, or how they fit into broader operational district planning. It is therefore recommended that KRCS make a concerted effort to proactively consult and coordinate with other relevant agencies and authorities, in order to ensure stronger networks are established for planning going forward for more connected, coherent programming.

ANNEX 1: Terms of Reference:

Terms of Reference for an End of Project Evaluation of the DG ECHO supported KRCS/IFRC project:
“Provision of Emergency Healthcare in Drought Affected Areas of Kenya” – ECHO contribution agreement n^o: ECHO/KEN/BUD2011/91011

1. Summary

- 1.1. Purpose:** The end of project evaluation intends to assess the effectiveness of the project design, and achievements of its results and objectives. It will also assess the efficiency of the implementation process. In addition, it shall draw some recommendations that would benefit design of future interventions.
- 1.2. Audience:** This evaluation will be used by the IFRC regional East Africa Office, the Africa Zone, Kenya Red Cross Society (KRCS), and at the international headquarters in Geneva.
- 1.3. Duration of consultancy:** approximately 3-4 weeks (with approx 1-2 weeks in the field)
- 1.4. Estimated dates of consultancy:** Mid-March – Mid-April 2012.
- 1.5. Location of consultancy:** Nairobi, and 2-3 selected target communities in areas of implementation, among these: **North Eastern province:** Elwak, Dadaab, Damajale, Holugo, Liboi, Amuma; **Rift Valley province:** Turkana districts, **Eastern province:** Isiolo.

2. Background

Kenya Red Cross Society (KRCS), supported by the International Federation of Red Cross and Red Crescent Societies (IFRC), is implementing an emergency health intervention in northern Kenya: *“Provision of emergency healthcare in drought affected areas of Kenya”*. The project aims a) at preparing for and responding to outbreaks of cholera, and b) at providing emergency healthcare for Somali refugees in the transition area between the Kenya/Somalia border and the Dadaab refugee camps.

The project period is 6 months and runs from October 1st 2011 to March 31st 2012. The project is funded by the European Commission Directorate General for Humanitarian Aid and Civil Protection (DG-ECHO), with a grant worth 1 million Euro, DG ECHO contribution agreement n^o: ECHO/KEN/BUD/2011/91011.

3. Evaluation Purpose & Scope

As part of the agreed project proposal, an end of project external evaluation is planned to take place. As per the signed project agreement: *“The project team will prepare terms of reference (TOR) for an end of project evaluation. The TOR will be shared and discussed with ECHO for approval. The end of project evaluation intends to assess the effectiveness of the project design, and achievements of its results and objectives. It will also assess the efficiency of the implementation process. In addition, it shall draw some*

recommendations that would benefit design of future interventions. IFRC and KRCS will share the output of the evaluation with relevant stakeholders such as MoPHS, Kenya Cholera Taskforce, UN and NGOs.”

4. Evaluation Objectives and Key Questions

The evaluation process shall seek to answer the following questions and address the following issues:

- **Relevance/appropriateness** – *“The extent to which the objectives of an intervention are consistent with the requirements of the beneficiaries”.*
I.e. are the outlined problems important to the beneficiaries, and is the project design optimally structured to address the outlined problems: a) outbreaks of cholera; b) emergency health needs among Somali refugees in the transition area between the Kenya-Somalia border and the Dadaab refugee camps ?
- **Efficiency** – *“A measure of how economically resources and inputs (funds, expertise, time, etc.) are converted to results”.*
I.e. has the project reduced morbidity and mortality significantly when looking at an overall budget of 1 million Euro ?
- **Effectiveness** – *“The extent to which the objectives were or are expected to be achieved, taking into account their relative importance”*
I.e. has or will the project meet the indicator targets: Case fatality rates in accordance with WHO / SPHERE standards ?
- **Impact** – *“The positive and negative, primary or secondary, short or long terms effects produced by the intervention, directly or indirectly, intended or unintended”.*
I.e. has the intervention made a difference, vis-a-vis the principle objective of the intervention, either short-lived or long-lived, contributing to reducing morbidity and mortality among populations living in drought and disaster affected areas of Kenya ?
- **Sustainability** – *“The continuation of benefits after the project implementation has ended. The probability of long-term benefits, and the resilience to risk of the benefits over time”.*
I.e. are the activities and the effects of the project likely to continue after external support has been completed ?

In addition, the evaluation shall consider the following criteria:

- **Connectedness** – *“The need to assure that activities of a short-term emergency nature are carried out in a context that takes longer-term and interconnected problems into account”.*
- **Coherence** – *The need to assess security, developmental, trade and military policies as well as humanitarian policies, to ensure that there is consistency and, in particular, that all policies take into account humanitarian and human rights considerations”.*

- **Coverage** – “The need to reach major population groups facing life-threatening suffering wherever they are”.

5. Evaluation Methodology & Process

The methodology will adhere to the draft IFRC Management Policy for Evaluations, with particular attention to the processes upholding the standards of how evaluations should be planned, managed, conducted, and utilized.

The **evaluation team** will consist of three people: one external evaluator, and one KRCS and one IFRC evaluator. The external evaluator will provide an independent, objective perspective as well as technical experience to the evaluation, and will be the primary author of the evaluation report. S/he should not have been involved or have a vested interest in the IFRC operation being evaluated, and will be hired through a transparent recruitment process, based on their professional experience, competence, ethics and integrity for this evaluation. The internal evaluators will provide IFRC background and experience to assist the external evaluator in the assessment process and to best interact with the various RCRC actors involved in the operation and this person should have sound knowledge and understanding of IFRC disaster response. It is expected that this three person team will be able to conduct a reliable and informed assessment of the emergency operation that has legitimacy and credibility with stakeholders.

The specific evaluation methodology will be detailed in close consultation between the evaluation team and IFRC, but will draw upon the following primary methods:

1. **Desktop review** of operation background documents, relevant organizational background and history, including prior IFRC evaluation reports, and any relevant internal and external documents, and sources of secondary data.
2. **Field visits/observations** to selected operation sites.
3. **Key informant interviews**, IFRC, KRCS, PNSs, aid agencies, local representatives and leaders, national entities including relevant ministries
4. **Focus group discussions**, focus on various groups benefited from the operation..

Two weeks after the start of the evaluation, a debriefing/discussion session (half day) to be organised by the evaluation team to highlight their main findings and review the evaluation process and next steps.

Initial first draft report will be prepared for a **review process**. It should occur within 1 week of the debriefing session and shall be submitted to the evaluation management team, see below. A review process will be carried out and will involve the following stakeholders in the following order:

Within a week of submitting the 1st draft: the evaluation management team will:

1. Check content is in line with TOR and standards
2. Share with **stakeholders** participating in the evaluation and collect their feedback.

3. Provide feedback on the report which includes input from evaluation team and other stakeholders.

Issues to be considered

- a. The evaluation management team – to be determined, but consisting of key stakeholders from within KRCS/IFRC will review the report and compile a management response to be included in the evaluation report.
- b. Acknowledging the challenging context and nature of stakeholder participation in this evaluation, a fifth week is included for unexpected delays in data collection, and report review and revision.
- c. The review process will be followed to ensure stakeholder input while maintaining the integrity and independence of the evaluation report according to the following lines.
 - **Inaccuracy.** Inaccuracies are factual, supported with undisputable evidence, and therefore should be corrected in the evaluation report itself.
 - **Clarifications.** A clarification is additional, explanatory information to what the evaluators provided in the report. It is the evaluators' decision whether to revise their report according to a clarification; if not, the evaluation management response team can decide whether to include the clarification in their management response.
 - **Difference of opinion.** A difference of opinion does not pertain to the findings (which are factual), but to the conclusions and/or recommendations. These may be expressed to the evaluators during the review process. It is the evaluators' decision whether to revise their report according to a difference of opinion; if not, the evaluation management response team can decide whether to include the clarification in their management response.
4. The evaluation team to prepare a final report following to receiving the feedback from the evaluation management team and submit it within a week.
5. The Evaluation management team to prepare a management response and submit it to KRCS and the IFRC EA regional office.

6. Evaluation Deliverables

Inception Report – The inception report will be a scoping exercise for the evaluation and will include the proposed methodologies, data collection and reporting plans with draft data collection tools such as interview guides, the allocation of roles and responsibilities within the team, a timeframe with firm dates for deliverables, and the travel and logistical arrangements for the team.

Debriefings / feedback to management at all levels – The team will report its preliminary findings to the IFRC (in-country, region, and zone) in a timely manner (2 weeks), before leaving the region, and will adhere to the above mentioned review process. The team leader will present the full draft report to evaluation management team within one week of the debriefing meeting. **Draft report** – A draft report,

identifying key findings, conclusions, recommendations and lessons for the current and future operation, and take in consideration the outputs of the debriefing session. .

Final report – The final report will contain a short executive summary (no more than 1,000 words) and a main body of the report (no more than 10,000 words) covering the background of the intervention evaluated, a description of the evaluation methods and limitations, findings, conclusions, lessons learned, clear recommendations. Recommendations should be specific and feasible. The report should also contain appropriate appendices, including a copy of the ToR, cited resources or bibliography, a list of those interviewed and any other relevant materials. The final evaluation report will be submitted one week after receipt of the consolidated feedback from IFRC.

All products arising from this evaluation will be owned by the IFRC. The evaluators will not be allowed, without prior authorization in writing, to present any of the analytical results as his or her own work or to make use of the evaluation results for private publication purposes.

7. Evaluation Quality & Ethical Standards

The evaluators should take all reasonable steps to ensure that the evaluation is designed and conducted to respect and protect the rights and welfare of the people and communities involved and to ensure that the evaluation is technically accurate and reliable, is conducted in a transparent and impartial manner, and contributes to organizational learning and accountability. Therefore, the evaluation team should adhere to the evaluation standards and applicable practices outlined in the IFRC Management Policy for Evaluation.

The IFRC evaluation standards are:

1. **Utility:** Evaluations must be useful and used.
2. **Feasibility:** Evaluations must be realistic, diplomatic, and managed in a sensible, cost effective manner.
3. **Ethics & Legality:** Evaluations must be conducted in an ethical and legal manner, with particular regard for the welfare of those involved in and affected by the evaluation.
4. **Impartiality & Independence;** Evaluations should be impartial, providing a comprehensive and unbiased assessment that takes into account the views of all stakeholders.
5. **Transparency:** Evaluation activities should reflect an attitude of openness and transparency.
6. **Accuracy:** Evaluations should be technical accurate, providing sufficient information about the data collection, analysis, and interpretation methods so that its worth or merit can be determined.
7. **Participation:** Stakeholders should be consulted and meaningfully involved in the evaluation process when feasible and appropriate.
8. **Collaboration:** Collaboration between key operating partners in the evaluation process improves the legitimacy and utility of the evaluation.

It is also expected that the evaluation will respect the seven Fundamental Principles of the Red Cross and Red Crescent: 1) humanity, 2) impartiality, 3) neutrality, 4) independence, 5) voluntary service, 6) unity, and 7) universality. Further information can be obtained about these Principles at: www.ifrc.org/what/values/principles/index.asp

8. Qualifications

Selection of the external evaluation consultant will be based on the following qualifications:

Demonstrable experience in leading evaluations of humanitarian programs responding to major disasters, with specific emphasis on emergency health and WatSan.

Knowledge of strategic and operational management of humanitarian operations and proven ability to provide strategic recommendations to key stakeholders;

Strong analytical skills and ability to clearly synthesize and present findings, draw practical conclusions, make recommendations and to prepare well-written reports in a timely manner;

Experience in qualitative data collection and data analysis techniques, especially in emergency operations;

Knowledge and experience working with the Red Cross Red Crescent Movement preferred;

Demonstrated capacity to work both independently and as part of a team;

Excellent English writing and presentation skills in English, with relevant writing samples of similar evaluation reports.

Regional knowledge of the Horn of Africa and Kenya in particular preferred but not required.

Minimum qualification of a Masters in relevant field of study, or equivalent combination of education and relevant work experience.

Availability for the period indicated.

ANNEX 2: EVALUATION WORKPLAN

KENYA RED CROSS SOCIETY EVALUATION PROGRAMME for ECHO funded EMERGENCY HEALTHCARE PROJECT

| Phase | Tasks | Timeline | Responsibility |
|--|---|---------------------|-------------------|
| Preparation | Literature Reviews | 4 days | Consultant |
| | Consultative interviews at HQ level | 12-17 July 2012 | Consultant |
| | Development of draft tools / questionnaires/discussion guides | | Consultant |
| | Preparation of materials | | Consultant |
| Field work / data collection – Isiolo | Travel to Isiolo | | 1 day – 18 July |
| | Key Information Interviews – KRCS branch, district level authorities (DMOH, DPHO, DEO, RHO, PO) | 2 days – 19-20 July | KRCS |
| | KII in Oldinyaro - with CHEW, school health club, CHU, focus group discussions | 2 days 21-22 July | KRCS |
| | KII in Merti – FGD Merti Health Centre management committee, KII Merti HC | 1 day 23 July | KRCS |
| | Debrief and final meetings in Isiolo, travel back to Nairobi | 1 day 24 July | KRCS |
| | Review documentation and follow up of pending issues, prep work for Turkana visit | 2 days 25-26 July | Consultant |
| Field work / data collection – Turkana | Flight Nairobi-Lodwar, KII interviews with KrCS staff | 1 day – 27 July | Consultant |
| | Travel to Turkana project sites, FGD with CHU | 1 day – 28 July | KRCS |
| | Review of documentation | 1 day – 29 July | Consultant |
| | KII (CHEW, School health club and patron) | 1 day -30 July | KRCS |
| | KII – DMOH, DPHO, DEO, RHO, PO, debrief with KRCS staff | 1 day – 1 August | Consultant |
| | Review documentation, follow up on pending issues, debrief IFRC, meeting with Finance | 2 days – 2-3 August | Consultant |
| Data collection / | Meetings with Dadaab staff, | 2 days 6-7 August | Consultant / KRCS |

| | | | |
|-------------------------|--|----------------------------|---------------------------------|
| Northeast Region | KRCS HQ health team | | |
| | KRCS HQ team meetings, IFRC engagement, finance | 1 day 8 August | Consultant, KRCS, IFRC |
| | Review of pending documentation and community health strategy / district area operational plans / DRR ECHO proposal | 1 day 9 August | Consultant |
| | Meeting – KRCS Daniel Lagat Northeast Regional Health Officer, review of final reporting, preparation for final reporting | 1 day 12 August | Consultant |
| Reporting | Drafting of initial report | 5 days 13-17 August | Consultant |
| | First draft submitted to KRCS and IFRC for review / comments | 17 August | Consultant |
| | Report returned with comments / clarification requests | 22 August | KRCS / IFRC |
| | Presentation of findings | 1 day 22 August | Consultant / KRCS / IFRC |
| | Revisions to report | 3 days 23-25 August | Consultant |
| | Final report submitted | 27 August 2012 | Consultant |

ANNEX 3: Stakeholders interviewed:

| Name | Position | Agency / Institution |
|---------------------------|--|-----------------------------------|
| 1. Torben Bruhn | Regional Health Coordinator | IFRC |
| 2. Vinay Sadavarte | Wat/San Advisor | IFRC |
| 3. Lily Murei | Senior Monitoring Evaluation & Learning Officer | IFRC |
| 4. Charlie Musoka | Operations Coordinator- Emergency Management Department | IFRC |
| 5. Caleb Chermirir | Public Health Manager | KRCS HQ |
| 6. Clare Howell | Monitoring & Evaluation Officer | KRCS HQ |
| 7. Daniel Adepo | Monitoring & Evaluation Officer | KRCS HQ |
| 8. Patrick Nyonza | Finance Manager | IFRC |
| 9. Vincent Kirui | Budget and Analysis Officer | KRCS HQ |
| 10. Ian Van Englegem | Regional Support Office | ECHO |
| 11. Isabelle D’Haute | Regional support Office | ECHO |
| 12. Mary Kariuki | Regional Health Officer | KRCS Upper Eastern Region |
| 13. Gregory Macharia | Project Officer | KRCS Upper Easter Region |
| 14. Alice Mwirigi | District Public Health Nurse | Isiolo District |
| 15. Joseph Gitonga | Deputy District Public Health Nurse | Isiolo District |
| 16. Jaoko O Benard | District Education Officer | Isiolo District |
| 17. Richard M. Luusah | District Public Health Officer | Isiolo District |
| 18. Kenneth Mutuma Mutema | Deputy Headmaster | Kipsing Primary School |
| 19. Asenyo Margaret | Patron – Health Club | Kipsing Primary School |
| 20. Samson Lematango | School Headteacher | Lobarishereki Primary School |
| 21. Nancy Kathambi | Deputy Head teacher & Health Club Patron | Lobarishereki Primary School |
| 22. Dimtu Guyo | Acting District Medical Officer | Merti District Health Centre |
| 23. Fauzia Mohammed | Regional Finance Officer | KRCS Isiolo Regional Office |
| 24. Justus Mbevi | Project Officer – EU Wat/San Project | KRCS Isiolo Regional Office |
| 25. Jerald Bombe | Regional Manager | KRCS Isiolo Regional Office |
| 26. Eric Mutwiri | Wat/San Officer, Focal Point for ECHO Emergency Healthcare Project | KRCS Turkana Office |
| 27. Nicodemus Okango | Branch Coordinator | KRCS Turkana Office |
| 28. Joseph Lugut | Acting District Public Health Officer | Turkana South District – Lokichar |
| 29. Patrick Kelengwe | Division Public Health Officer | Katilu Division |

| | | |
|----------------------|---|--|
| 30. Jackson Achmkary | Deputy Principal, Patron of Health Club | Katilu Girls Secondary School |
| 31. Julie Akorilem | Ag District Public Health Officer, Community Health Strategy Focal Point | Loima District, Turkana Central |
| 32. Omwenga Kwaba | Deputy Public Health Officer | Lodwar District Hospital, Turkana Central |
| 33. James Mwangi | Emergency Health Manager, Health Coordinator | KRCS Dadaab |
| 34. Daniel Lagat | Regional Health Officer | KRCS Northeast Region |
| 35. Dr Nasra Ali | Head of Health and Social Services | KRCS HQ |
| 36. Nzuki Waita | DRR / Food Security Advisor | KRCS HQ |

Focus Group Discussion – Health Club Participants, Kipsing Primary School (18 July 2012)

1. Simon Lenamoira, 15 years old
2. Francisca Atabo, 16 years old
3. Frederick Loningo Lemakima, 13 years old
4. Veronica Lempurkel, 14 years old
5. Kevin Moni, 14 years old
6. Priscillah Ekuwam, 15 years old
7. Jackline Purity, 15 years old

Focus Group Discussion – Community Health Workers & KRCS Volunteers, Kipsing Dispensary (19 July 2012)

1. John Lochuch, Community Health Committee, KRCS Volunteer
2. Teresia Eminaie, Community Health Committee, KRCS Volunteer
3. Dominic Lenayasa, Community Health Worker, KRCS Volunteer
4. Rose Nakayo, KRCS Volunteer
5. Moses Lotukoi, KRCS Volunteer
6. John Lewai, Community Health Worker, KRCS Volunteer
7. Patrick Lemeriwai, Community Health Worker, KRCS Volunteer
8. Thomas Lesasuyan, Community Health Committee, Community Health Worker
9. Martin Moni, Community Health Worker, KRCS Volunteer
10. James Lempatu, Community Health Committee, Community Health Worker
11. Ltaason Leimau, KRCS Volunteer

Focus Group Discussion – Community Health Workers and Committee, Oldinyaro (21 July 2012)

1. Peter Molka, KRCS Volunteer, Community Health Worker, Community Health Committee
2. Christopher Okoyo, KRCS Volunteer, Community Health Worker
3. Jackson Emejen, KRCS Volunteer, Community Health Worker
4. John Lekalkuli, Community Health Worker
5. Joseph Lenengwesi, Community Health Worker
6. Jennifer Lesasuyan, KRCS Volunteer, Community Health Worker
7. Judy Ekeno, KRCS Volunteer, Community Health Worker
8. Mary Pererian, KRCS Volunteer, Community Health Worker
9. Phelitus Silantoi, KRCS Volunteer, Community Health Worker
10. Kwakan Cecilia, KRCS Volunteer, Community Health Worker
11. Peter Lempug, KRCS Volunteer, Community Health Worker
12. Felix Gituma Kweta, Community Health Extension Worker, Community Health Committee
13. Lucy Mbaya, Nurse

Focus Group Discussion – Merti Community Health Committee (23 July 2012)

1. Jarso Guyo, Chairman
2. Dokaw Halkawo, Member
3. Fatuma Duba, Member
4. Saiio Bonaya, Treasurer
5. Abkui Godana, Member

Focus Group Discussion: Lokichar (Turkana) Community Health Workers / Unit (28 July 2012)

1. Paule Esikirea Enock, Community Health Committee Chairperson – Kapese Unit
2. Joseph Ekiru Lotokos, Community Health Committee Chairperson – Kamarese Unit
3. Akiru Alany, Community Health Worker
4. Alice Ekal, Community Health Extension Workers
5. Elizabeth Korikel, Community Health Worker
6. Dominic Logalaln, Community Health Worker

Focus Group Discussion: Loima Community Health Unit (30 July 2012)

1. Nelly Cherup, Public Health Officer, Community Health Extension Worker
2. Joseph Etabo, Community Health Worker
3. Emmanuel Illikweg, Community Health Worker
4. John Ebongon, Community Health Worker
5. Nicodemus Esekon Erebon, Community Health Worker
6. Gadpeter Lopusiki, Community Health Worker
7. Anthony Ilikwell, Community Health Worker

ANNEX 4: EVALUATION FRAMEWORK / GUIDING QUESTIONS FOR INTERVIEWS AND FGDS:

I. At HQ level – NAIROBI: *Question for the KRCS management* :

1. What was the reaction from the KRCS HQ when there was warning of the potential for a cholera outbreak? How long after the warnings did the KRCS decide to launch the ECHO appeal?
2. What instructions were sent to the district branches?
3. What worked well during the operation?
4. What were the weaknesses / needs to be improved? How? (or challenges and the way forward)
(main aspects of relief: needs assessment, planning for the programme activities, procurement, transportation, allocation, selection of beneficiaries, distribution, financial management, monitoring and supervision, coordination with the Federation, the Government and other organisations, communication, information and reporting)
5. What impact did this operation and support provided have on the affected and targeted populations / communities? What are the longer term implications for sustainability?
6. Main Lessons learned for future potential operations?
7. What guidance or instructions were sent to the branch chapters?
8. What support did you receive from the HQ in terms of guidance, management, human and financial resources?
9. What requests for support did you receive from the branches? How did you deal with those requests?
10. What kinds of training were organised for the staff and volunteers involved in the operation? How did previous trainings or capacity building initiatives help staff and volunteers in undertaking their tasks?
11. What are the successes and challenges of this operation?
(main aspects of relief: emergency fund, stock relief, needs assessment, planning for the programme activities, procurement, transportation, allocation, selection of beneficiaries, distribution, financial management, monitoring and supervision, coordination with the Federation, the Government and other organisations, communication, information and Reporting)
12. What was the most significant improvement from this operation compared to previous ones?
13. What can be done by KRCS to address the challenges and to improve the quality, timeliness and effectiveness of future operations?

QUESTIONS ABOUT THE PROJECT IMPLEMENTATION

1. How were the targeted communities and community health units selected? Were supplies appropriate and responsive to needs at the right time?
2. How were the supplies and materials distributed? By whom? In timely manner?
3. Were feedback mechanisms established? Was any feedback received? How was feedback actioned, and by whom? Were any modifications made during implementation?
4. Who supervised the at field level operations? In partnership with...?

GENERAL QS ABOUT AFFECTED DISTRICTS

1. How were local people affected by the response?
2. What did the local authorities, other aid organisations and the communities themselves do to help in the design and roll out of the project?
3. What is the role of the KRCS in health response (as perceived by the RC staff and the government officials)?
4. How did the RC cooperate and coordinate with the local authorities and other organisations?
5. Was there a contingency plan for health in the districts? Any early warning / action mechanism established? If yes, what were the main components? How were these developed? By whom?
6. Were emergency or contingency funds utilized efficiently / effectively? How much?
7. How were the beneficiary communities selected? What are the selection criteria? What difficulties were there in the selection process? Who were involved in the selection?
8. What were the tasks of volunteers? How were they mobilised?
9. What guidelines or technical support did the District Branch receive from higher levels? What other support from the NHQ would you like to have to implement the relief operation better?
10. What changes to the life of the communities compared to pre response situation?
11. What did the beneficiary population contribute to the project? What was received (if anything) from other communities? From other agencies...

**QS FOR FOCUS GROUP DISCUSSIONS WITH VOLUNTEERS & COMMUNITY:
(thematic areas of discussion):**

Training and application

- *Question for group discussion (in groups 5 -7):*

1. What training did you receive before the EMERGENCY, from who?
2. How did these knowledge and skills help you in implementation of the project, especially in health promotion, surveillance, hygiene / sanitation management?
2. What difficulties did you meet in applying the knowledge?
3. What are other knowledge/skills are needed to help you work better?

Programme management

- *Question for discussion group 1 of RC staff:*

1. What were the strengths and weaknesses of the operation?
2. What should be done to maintain the strengths and to improve the weaknesses?
3. How did you communicate PHAST programme related information with other organisations and within your organisation?
4. What are strengths and weakness of the current communication system? How can it be improved?

Open-ended questions for in-depth interview

1. General information about the household (members, male/female, economic situation, ethnic group, religion, etc.)
2. Did your family know that there was a risk of cholera? How did you know? If yes: what did your family do to respond?
3. What did you know about the hygiene / phast planning? What activities were there? How did you contribute to the plan preparation and implementation?

4. How was your family and other people in the District affected by the project?
5. What support did you receive? Did they meet your needs? From who or which organisation?
6. How did these activities help you and your family? If you did not receive these support, why not and what sort of support would you have wanted?
7. How were you selected for involvement in the activities? Why were you selected?
8. How will you use this knowledge / new skills in future?
9. What did your family contribute to ensuring safe health practices in your household and community?
10. What other training /support did your family receive from other community members and other organisations?
11. What can be done to prepare better for and reduce the impact of future outbreaks or health emergencies? (by your family? By community people? By local authorities and other org.?)

I. FOR DOCUMENTATION REVIEW:

Project administrative history and organization
 Financial systems
 Project M&E systems and indicator updates - LOGFRAME
 The project's technical components – Health Unit / Watsan input
 Community/activity matrices
 MoH district reports (monthly?)
 Baseline Surveys / Needs Assessment Information
 Maps

II. FOR KRCS STAFF:

Theme 1: Relevance. *To what extent was the project relevant to the needs of the affected population – based on what assessment information - and take into account impacts on the ground?*

- Current health situation in project area
- Alignment with MoH priorities, policies and programs
- Alignment with national needs?
- Identification of most vulnerable?
- Objectives and indicators appropriate? Alignment with national health strategy?
- Management and institutional arrangements appropriate?

Theme 2: Effectiveness. *To what extent has the project achieved the stated objectives?*

- The significant changes in the community response that health Projects have contributed to.
- How health leadership was built and could be maintained, especially at the national, district and community levels.
- What an expanded health response means to stakeholders and examples of this response
- How integrated health programs were reached and how quality of service provision was maintained.
- What led to improved ownership and responsibility – or not - by GoK partners and communities.
- What the impact of activities for communities, organisations and institutions that received direct support and vulnerable and affected populations that benefited from the Program assisted activities and services (beneficiaries) was, the associated behaviour change, and or challenges.
- How those who attended trainings and capacity-building exercises applied their knowledge and skills in practice and maintained competence.

- What systems were in place to encourage the institutionalisation of evidence-based planning and review cycles to support a multi-sector or integrated response at all levels.
- The monitoring and evaluation of Project activities – in particular the use of qualitative measures alongside quantitative measures.
- An indication of the Project's value for money and the cost-benefit.
- How risks were identified and managed over the Project's lifetime.
- The sourcing and maintenance of funding for Project initiated activities.

Theme 3: Efficiency. *To what extent have the existing implementation and coordination processes, as well as the resources available, contributed to a positive impact?*

- Management impact on achievement of outcomes for health
- How is the relationship with MoH?
- What is the impact of KRCS, IFRC, and ECHO on the health program?
- Any changes anywhere in the health program as a result of donor, staff or community input and what has been the impact of this on the program's progress.
- What is the risk for behaviour change being maintained?
- How is procurement of health materials and equipment maintained – e.g. ORS, antibiotics
- Were technical advisers provided? How were their inputs identified? How were their inputs managed? Were timing of inputs appropriate – any evidence of clashes with key events, or overlapping/duplication of inputs?)
- Was the 6 month project considered cost effective?
- Are there any plans to look at cost-benefit analysis of the project?
- How is value for money assessed?
- How were resource allocations weighted? Different per district, reflect diversity and differences in sizes of population, risk, etc?
- Any evidence of cost-sharing with other agencies, such as the MoH or local partners?
- Evidence of integration of health components into MoH or other agencies to reduce costs?
- Evidence of leveraging resources (material, human, financial) for scaling up?

Theme4: Coherence/complementarity. *How did KRCS approach fit into the larger drought response context and facilitates transition to longer term sustainable strategies?*

MONITORING

- How was monitoring used to inform planning?
- How regular was monitoring reviewed for improvement?
- Is there currently existence of both a range of qualitative and quantitative information?
- How often was technical advice provided – from IFRC delegates and externally?
- What was used as baseline for the emergency response? Is this in line with MoH policy? Has that been revisited with monitoring?
- How can it be demonstrated that specific activities positively affected the health prospects of beneficiaries with few or no resources?
- Do monitoring indicators best reflect gains in health or steps to achieve better health?
- Was there an M&E framework developed? Was it satisfactory?

- Was project planning evidence-based (based on baseline information and consultation with MoH and other partners/NGOs)
- Is there a knowledge management strategy – used for policy/program development.
- Identification of unexpected outputs – positive or negative and evidence of response

Theme5. SUSTAINABILITY

- Scale-up and/or replication of initiatives – models and approaches providing learning? Especially for other districts to respond.
- Technical sustainability: any examples of Project trained staff being asked to provide advices and support in other districts/NGOs/Agencies? Any increase in ownership of technical aspects being increasingly owned by MoH or other NGOs, or inclusion of community health workers / volunteers in other similar activities?
- Financial sustainability: any increase in local District or MoH budgets for health as a result of lobbying/advocacy? Any increase in donors?
- How are capacity building activities across health activities monitored and supervised?
- How is capacity building, mentoring, knowledge and skills transferred to local communities and agencies
- Sustaining behaviour change after project end? How monitored?
- How important was it to have capacity building activities to improve health outputs/outcomes and responses from communities and other agencies?

Theme 6:COORDINATION, GOVERNANCE, PARTNERSHIP

- Coordination with other drought response activities?
- Coordination with MoH?
- Coordination with other agencies/NGOs?
- Development of robust MoU with MoH?
- Evidence of recipients/communities involvement in development of health program
- Support for MoH, agencies/NGOs to participate in policy and program development
- Building and transfer of financial, planning and management skills – coupled with monitoring?
- Any health programs now able to be seen as MoH activities?
- Issues affecting attracting and keeping competent staff?

Theme 7: Cross-cutting issues: *To what extent has the ECHO project taken into account cross-cutting issues such as gender, children, environmental protection and HIV/AIDS, in the planning and implementation of the action?*

- How do you know if contributing or not to gender equity?
- What range of gender specific foci have been implemented across the Health Project's components?
- Are outcome based gender indicators included in Project's logframe targets – also at Objective level?
- Are gender issues included in training programs and master trainer curriculum?
- Any indication of increased involvement of women or women's groups/organizations in project activities

III. TECHNICAL ISSUES:

Cholera Indicators:

Reported number of cases (and deaths) of cholera: The number of cases (and deaths) of cholera reported to the Department of Health.

Case fatality rate (CFR): Number of deaths divided by number of cases expressed as a percentage. The CFR is used to monitor the quality of case management.

Attack rate (Incidence): Number of cases per 100 000 population at risk.(This indicator used to gauge the severity of the outbreak. Severely affected countries have reported national attack rates of between 1% and 10% of the population.)

Gender, age and ethnic group distribution of Cases

An average of **% reduction in cholera incidence between start and end of project implementation

TECHNICAL ASSESSMENT OF THE OUTBREAK AND RESPONSE

1. What measures have been taken to control the outbreak):

- legal decisions (banning of festivals, inspection of food handlers and restaurants, etc.)?
- assistance provided to affected areas (supplies, technical and staff support)?
- health education campaigns?
- timely and adequate mobilization of emergency supplies from national or donor sources?
- information campaigns and use of media?
- training organized (in surveillance or case management)?

3. How was the response monitored:

- follow-up of the outbreak through regular epidemiological reports?
- impact of control activities on epidemiological trends?
- field investigation to identify the source of contamination?

4. Who was the person designated to monitor and document control activities?

5. Was a cholera emergency plan of action available?

6. Was there an easy information flow from the affected areas to the control level and vice versa?

PREPAREDNESS

Was a cholera emergency plan developed and in place?, including the following essential elements of outbreak preparedness and response :

- plan logistics (what is available, what is needed);
- plan staff responsibilities (reassignment of staff according to needs, decision on who is responsible at each level);
- ensure availability of financial support for preparation and response (costs of the investigation and the response, sources of funding);

Were the resources that were needed available);

- plan for providing safe water and ensuring safe disposal of excreta, and for education campaigns (materials, methodology, staff).

EFFECTIVENESS

1. Were the cholera treatment units located close to the most affected communities?

2. Were there hand-washing facilities in the cholera treatment centre? Were the patients' relatives washing their hands every time they leave the centre?
3. Were the cholera treatment units organized in four areas – selection and observation, hospitalization, convalescent room for ORS treatment, neutral area (for kitchen, stocks of material, etc.)?
4. Were measures in place for the safe disposal of excreta and vomit? Were there special latrines for cholera patients who can walk, separated from latrines used by the rest of the patients?
5. Was there enough water to cover the daily needs of patients (50 litres/person)?
6. Were buckets, latrines, clothes, and bedding properly disinfected ?
7. Were cholera cots available?

INFORMATION EDUCATION COMMUNICATION

1. Was health education an important part of the response?
2. Were the messages spread illustrated by practical demonstrations (e.g. chlorination of water, preparation of ORS)?
3. Were the messages elaborated with the community?
4. Were the messages disseminated through community or religious leaders or through any channel that reaches the maximum of people with greatest impact on their behaviours?
5. Were the messages adapted to local cultural beliefs about the disease and to the capacity for implementing control measures in the community (e.g. if soap is unavailable, have ashes been recommended for washing hands)?
6. Have efforts been made to encourage the use of latrines?
7. Was there active case-finding in the community ?
8. Were education messages given to the patients and their relatives in health care facilities?
9. Were health care workers able to disseminate the appropriate messages?

MANAGEMENT OF RESPONSE

1. Were the different sources of contaminated water been identified ?
2. Were these sources been disinfected during the outbreak?
3. If wells were chlorinated, was there regular monitoring of residual chlorine?
4. What measures were recommended to avoid contamination of water ?
5. Where chlorination of a water source was not possible, was there any programme to ensure safe drinking-water at household level?
6. Were chemicals for water disinfection (chlorine compounds) available in the local market at affordable prices?
7. Was there any system for providing safe water to high-risk communities during the outbreak?
8. Did the population receive a supply of at least 20 litres of safe water per day per person?
9. Were health workers properly trained to teach local people about hygiene and disinfection techniques?
10. Was the community informed about preventing water contamination?

IMPACT

1. What percentage of the population was served with improved sanitation facilities ?
2. Was there a good system in place for excreta management and disposal during the outbreak (latrine emptying and sludge removal from septic tanks)?
3. Were the sanitation facilities vulnerable to flooding or other natural disasters?
4. Could the sanitation facilities potentially contaminate any drinking water sources?

5. Was consideration given to providing sanitation services for high-risk communities during the outbreak?
6. Were health workers properly trained to teach local people about good hygiene behaviours

BASIC ANALYSIS

1. Were data from previous outbreaks available and used to provide better understanding of the current outbreak?
2. Was there a good analysis of data by time, area, and high-risk group during the outbreak?
3. Was the information collected and analysed promptly enough to be used in monitoring the outbreak?
4. Did health care workers understand the purpose of collecting information?
5. Was information available and easily understandable to decision makers (e.g. members of the cholera coordination committee)?

COORDINATION

1. What mechanisms were established to involve international partners (United Nations agencies, NGOs, international donors, private sector) in the outbreak response, in addition to health authorities?
2. Was a list of needs that might be supported by international partners been established
3. Was there any formal mechanism for raising funds to support the outbreak response?
4. Which organization was coordinating the various partners involved in the outbreak response ?
5. Was there any strategic plan for the response, with specific tasks assigned to each partner
6. What was the role of KRCS in the outbreak response (coordination, financial support, technical support)? At what level was HQ, regional level, country level, district level, IFRC involved?

ANNEX 6: DOCUMENTATION REVIEWED

1. PROVISION OF EMERGENCY HEALTHCARE IN DROUGHT AFFECTED AREAS OF KENYA – ECHO Proposal
2. KRCS Emergency Healthcare Project Budget 2011-12
3. Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of Level One Services (Govt of Kenya, Ministry of Health)
4. ECHO Intermediate Report, February 2012
5. Health Facility Line Listing Form, 503, Northeast Region
6. Facility Mapping ECHO concepts Northeast Region
7. Facility Mapping ECHO concepts Turkana
8. ECHO Emergency Healthcare Project Workplan
9. HEALTH and NUTRITION SECTOR UPDATE DADAAB REFUGEE CAMPS 4-10 February, 2012
Epidemiological week 6
10. HEALTH and NUTRITION SECTOR UPDATE DADAAB REFUGEE CAMPS 11TH-17TH February, 2012
Epidemiological week 7
11. COMMUNITY HEALTH WORKER– VERBAL AUTOPSY format
12. Final ECHO Project Report – Turkana District (8 July 2012)
13. Final ECHO Project Report – Isiolo District (8 July 12)
14. Final ECHO Project Report – Northeast Region (10 August 2012)
15. Report on the findings of a mass MUAC screening carried out in Ifo, Ifo 2, Dagahaley, Hagadera and Kambioos camps from 26th to 30th March, 2012
16. Harmonization Policy for payment of Refugee Incentive Wages 2012
17. HEALTH and NUTRITION SECTOR UPDATE DADAAB REFUGEE CAMPS 14TH-20TH January, 2012
Epidemiological week 3, Update No. 27
18. Health and Nutrition Update UNHCR Week 4, February 2012
19. Ifo Camp II Profile, May 2012
20. CONSOLIDATED DISTRICT HEALTH SECTOR PLAN 2011/2012 ISIOLO DISTRICT
21. IFRC Emergency Operation Appeal Update: Kenya Drought (*MDRKE016*, 25 May 2012)
22. MINUTES OF THE Isiolo DISTRICT HEALTH STAKEHOLDERS FORUM 21 JUNE 2012
23. Emergency Healthcare Project Isiolo District Achievements Overview
24. Isiolo Draft Sustainability Plan for Emergency Healthcare Project (June 2012)
25. Upper Eastern Region Health and Social Services Weekly Update, April 2012
26. Upper Eastern Region Health and Social Services Weekly Update, May 2012
27. Acute Watery Diarrhea Sample Line Lists (x4), Dadaab
28. Ifo II Individual Camp monthly health Reports (November – May 2012)
29. IFRC Appeal to ECHO for Drought Risk Reduction and Drought Response in the Horn of Africa (June 2012)
30. ECHO financial report August 2012 (draft)

ANNEX 7: OVERVIEW OF INTERVENTIONS PER FINAL ECHO REPORT

| | Details | Total beneficiary | Current status | Upper Eastern | North Eastern | Turkana | Cumulative status |
|----------------------------|---|-------------------|---------------------------------|--|--|---|---|
| Community Health Strategy: | 19 Community Units with 5,000 people each | 95,000 | 0 | 6 CHUs with 30,688 people. | 9 CHUs with 108,722 people | 3 CHUs with average of 5000 people (15,000) | 154,410 |
| Medical Outreach: | 60 medical outreach days (10 operational days per month for 6 months) with 150 patients seen daily per outreach day | 9,000 | 9,983 | 5 medical outreaches were conducted for IDPs within Isiolo District targeting over 800 households. 467 patients were treated during the exercise | NIL | 0 | 10,450 |
| House to House visits: | 100 volunteers visiting 5 Households everyday (average pop per H/H is 6) for 90 days | 270,000 | 0 | 56 Vols and CHWs involved in door to door visits to 5 HH everyday (average pop per hh 6) for an average of 45 days = 75,600 | 360 volunteers visiting 4 HH everyday (avarage pop per hh 6) for an avarage of 32 days – 276,480 | 160 CHWs visiting an average of 3 h/h everyday (average pop per h/h 6) for average 25 days 67500 persons reached. | 419,580 |
| Health Facilities | 6 health facilities supported with an average of 50 patients per day for 120 working days (20 working days per months for 6 months) | 36,000 | 1,123 (cholera cases in Daadab) | 1 health facility in Merti District has a Cholera wing being built | 1,130 cases in Dadaab | 0 | 6 health facilities supported with equipments and drugs. One of them was supported with |

| | | | | | | | |
|-------------------------------|---|----------------|--|--|---|---|---|
| | | | | | | | construction. |
| Hygiene and Sanitation events | PHAST: 100 volunteers visiting 5 Households everyday (average pop per H/H is 6) for 40 days | 120,000 | 133,085 (69,085 Mander Central and 64000 Daadab) | PHAST: 56 volunteers and conducted house to house visits targeting 4327 house hold with a population of 21,998 people | 69085 in Dadaab, 64,000 in Mander central, Wajir West, 12,302 in Saka and 10,040 in Tana North District). 165,531 | CLTs training and triggering of three villages, 70 latrines constructed. 67,500 HHs visited | 106 volunteers were trained on PHASTER who conducted hygiene promotion and reaching out to a total of 255,029 people. |
| | SHEPP: Work with 10 schools with population of average 400 pupils | 4,000 | 0 | SHEPP: worked with 6 schools in which 12 teachers were trained to reach a population of 1,926 pupils using 6 health clubs. | 2,000 school going children reached. | 10 teacher trained from four schools average pop 350. 1,400 | 5,326 |
| | CLTS: Work with 19 Communities average 5,000 people | 95,000 | 0 | CLTS triggered in 6 CUs. 30,688 reached | 108,722 pax reached through 9 CUs | 3 Community Units with average of 5000 people (15,000) | 154,410 |
| | TOTAL DIRECT BENEFICIARIES | 629,000 | 144,191 | | | | 999,205 |

ANNEX 8 STATUS OF MERTI CHOLERA WARD



Figure 1 Merti Cholera Ward as of 17 August 2012: Photo Courtesy of KRCS